CHAPTER 4

Physician and other health professional services

RECOMMENDATION

4 For calendar year 2022, the Congress should update the 2021 Medicare payment rates for physician and other health professional services by the amounts determined under current law.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

CHAPTER 4

Physician and other health professional services

Chapter summary

Physicians and other health professionals deliver a wide range of services—including office visits, surgical procedures, and diagnostic and therapeutic services—in a variety of settings. Medicare pays for these clinician services using a fee schedule. In 2019, Medicare paid $73.5 billion for clinician services, accounting for just under 18 percent of traditional fee-for-service (FFS) Medicare spending. In the same year, almost 1.3 million clinicians billed the fee schedule, including physicians, nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

In this chapter we recommend a payment rate update for the conversion factor (a fixed dollar amount) for Medicare's fee schedule for 2022. Because of standard data lags, the most recent complete data we have for most payment adequacy indicators are from 2019. Where relevant, we have considered the effects of the 2020 coronavirus pandemic on our indicators and whether those effects are likely to be temporary or permanent. To the extent the effects of the pandemic are temporary or vary significantly across clinicians, they are best addressed through targeted temporary funding policies rather than a permanent change to all clinicians' payment rates in 2022 and future years. Based on information available at the time of publication, we do not anticipate any long-term effects related to the public health emergency that would warrant changing the annual update to Medicare's fee schedule for 2022.

In this chapter

- Are Medicare fee schedule payments adequate in 2021?
- How should Medicare payments change in 2022?
- Appendix: Findings from the Commission's 2020 access-to-care telephone survey

Assessment of payment adequacy

To assess the adequacy of current payment rates for clinicians, we assess beneficiaries' access to care, the quality of their care, and providers' payments and costs.

Beneficiaries' access to care—Overall, beneficiaries' access to clinician services is comparable with prior years, despite the current public health emergency.

- ***Beneficiaries report relatively good access to care.*** Consistent with longstanding trends, the vast majority of beneficiaries reported having a usual source of care and that their usual care provider spent enough time with them. In the Commission's 2020 telephone survey, we also found that higher shares of Medicare beneficiaries reported being satisfied with their care and reported having a primary care provider than did privately insured individuals. Despite being fielded during a pandemic, our survey also found no statistically significant increase this year in the share of respondents who waited longer than they wanted for appointments or who reported forgoing care. This finding may in part be attributable to the substitution of telehealth visits for in-person visits: 15 percent of beneficiaries reported having a video visit in the past year, and 37 percent reported having an audio-only phone visit. Although a majority of beneficiaries reported being able to find a new doctor without any problem, among the small share who reported difficulties, more beneficiaries reported problems obtaining a new primary care provider than obtaining a new specialist. We also found that Black beneficiaries reported more problems finding a new specialist than did White beneficiaries, and Hispanic beneficiaries reported longer waits for appointments. Non-elderly Medicare beneficiaries (most of whom qualify for the program because of disability and have lower incomes than elderly beneficiaries) reported noticeably more difficulties accessing care than did elderly beneficiaries.
- ***The supply of clinicians continues to grow.*** From 2014 to 2019, growth in the number of clinicians billing the fee schedule outpaced growth in the number of beneficiaries. However, during this time, the mix of clinicians changed: The number of primary care physicians decreased slightly, while the number of specialists steadily increased, and the number of advanced practice registered nurses and physician assistants grew rapidly. The share of providers billing Medicare who are enrolled in Medicare's participating provider program—meaning they accept fee schedule amounts as payment in full—remains very high.
- ***The number of clinician encounters per beneficiary is growing.*** The number of clinician encounters per beneficiary increased modestly over time, with faster growth from 2018 to 2019 (2.1 percent) compared with the average

annual growth rate from 2014 to 2018 (1.1 percent). Growth rates varied by specialty and type of provider. From 2018 to 2019, the number of encounters per beneficiary with primary care physicians declined by 2.3 percent, while encounters per beneficiary with advanced practice registered nurses and physician assistants increased by 10.9 percent. These findings suggest that beneficiaries are able to access the care they seek even though different clinicians may be furnishing it.

Quality of care—Geographic variation in traditional Medicare beneficiaries' ambulatory care–sensitive hospitalizations and emergency department visits signals opportunities to improve the quality of ambulatory care. There is substantial use of low-value care among Medicare beneficiaries. (Low-value care is the provision of a service that has little or no clinical benefit or care in which the risk of harm from the service outweighs its potential benefit.) We estimate that, in 2018, between 22 percent and 36 percent of beneficiaries in traditional Medicare received at least one low-value service, and Medicare spending for these services ranged from $2.4 billion to $6.9 billion.

Medicare payments and providers' costs—Clinicians' Medicare payments and input costs continue to rise.

- ***Medicare payments per beneficiary are growing.*** Between 2018 and 2019, traditional Medicare's allowed charges (i.e., payments to providers, including beneficiary cost sharing) for clinician services per beneficiary grew 3.7 percent, a higher growth rate than in prior years. Among broad service categories, allowed charges for evaluation and management services between 2018 and 2019 grew 2.9 percent, while imaging services grew 3.5 percent, major procedures grew 5.1 percent, other procedures grew 5.6 percent, and anesthesia services grew 2.6 percent.
- ***Private insurance payment rates continue to be higher than Medicare payment rates.*** In 2019, private insurance payment rates for clinician services were 136 percent of traditional Medicare's rates, up slightly from 135 percent in 2018. The growth of private insurance prices could be a result of increased consolidation of physician practices, which gives physicians greater leverage to negotiate higher prices with private plans.
- ***Physician compensation is rising.*** From 2015 to 2019, median physician compensation from all payers grew by 3.3 percent per year, on average. However, median compensation in 2019 remains much lower for primary care physicians than for physicians in certain other specialties, such as radiology and surgical specialties—underscoring concerns about the mispricing of fee schedule services and its impact on primary care.

- ***Clinicians' input costs are growing.*** In 2019, the Medicare Economic Index—which measures input costs—grew by 1.5 percent. CMS projected that it would increase by 1.7 percent in 2020 and that it will increase by 1.3 percent in 2021 and 1.6 percent in 2022

How should payment rates change in 2022?

The Medicare Access and CHIP Reauthorization Act of 2015 mandates no update for clinicians for 2022 (however, clinicians are eligible for performance-based payment adjustments or can receive an incentive payment worth 5 percent of their professional services payments if they participate in an advanced alternative payment model). The Commission's analyses suggest that Medicare's aggregate payments for clinicians are adequate. Therefore, the Commission recommends that the Congress update the 2022 Medicare payment rates for physician and other health professional services by the amounts determined under current law. ■

Background

Physicians and other health professionals billing under traditional Medicare's physician fee schedule deliver a wide range of services—including office visits, surgical procedures, and diagnostic and therapeutic services—in a variety of settings.[1] The Medicare program paid $73.5 billion for clinician services in 2019, or just under 18 percent of spending in fee-for-service (FFS) Medicare (Boards of Trustees 2020).[2] In 2019, almost 1.3 million clinicians, including physicians, nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners, billed traditional Medicare for at least one beneficiary.

Medicare uses a fee schedule to pay for clinician services, which consists of about 8,000 services. In determining payment rates for each service, CMS considers the amount of clinician work required to provide a service, expenses related to maintaining a practice, and professional liability insurance costs. These three factors are adjusted for variation in the input prices in different markets, and the sum is multiplied by the fee schedule's conversion factor (a fixed dollar amount) to produce a total payment amount.[3] The conversion factor was $36.09 in 2020.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a set of updates for clinicians billing under the fee schedule. MACRA established two paths: (1) a payment path for clinicians who participate in advanced alternative payment models (A–APMs), such as the Comprehensive Primary Care Plus model or certain accountable care organization models, and (2) the Merit-based Incentive Payment System (MIPS) for other clinicians (Table 4-1).

For 2022, there is no update to clinicians' base payment rates scheduled under current law. Instead, clinicians qualifying for the A–APM incentive payment will receive a lump sum payment worth 5 percent of their annual professional services payments. MACRA allows CMS to give the clinicians in MIPS payment adjustments between –9 percent and +9 percent (or higher) in 2022 based on

TABLE 4–1

Clinicians are eligible for MIPS performance-based payment adjustments and A–APM bonuses, but no updates to their base payment rates in 2022

	2021	2022	2023	2024	2025	2026 and later
A–APM clinicians						
Update	0%	0%	0%	0%	0%	0.75%
A–APM bonus	5%	5%	5%	5%	N/A	N/A
Other clinicians						
Update	0%	0%	0%	0%	0%	0.25%
Potential MIPS adjustments	(–7% to +7%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)
Additional MIPS adjustments for "exceptional" performance	$500 million	$500 million	$500 million	$500 million	N/A	N/A
All clinicians						
One-time payment increase	3.75%	N/A	N/A	N/A	N/A	N/A

Note: MIPS (Merit-based Incentive Payment System), A–APM (advanced alternative payment model), N/A (not applicable). The annual change to the conversion factor (a fixed dollar amount) for Medicare's physician fee schedule is based on the statutory payment updates listed above and an adjustment to ensure that changes to the fee schedule's work relative value units are budget neutral. The 5 percent incentive payment for A–APM participation expires after 2024, as does the additional $500 million per year used to increase MIPS adjustments for "exceptional" performance. In the Consolidated Appropriation Act of 2021, the Congress increased fee schedule payments by 3.75 percent in 2021 only; this increase does not continue after 2021.

Source: Medicare Access and CHIP Reauthorization Act of 2015; Bipartisan Budget Act of 2018; and Consolidated Appropriations Act, 2021. www.congress.gov.

The impact of the coronavirus pandemic on clinicians

To examine the impact of the coronavirus pandemic on clinician services in Medicare, we analyzed preliminary Medicare fee-for-service (FFS) claims data for physician fee schedule (PFS) services furnished during the first six months of 2020. We found that allowed charges (i.e., total payments to providers, including beneficiary cost sharing) for clinician services dropped sharply starting in March 2020. By April 2020, total allowed charges were roughly half what they were in April 2019. Some types of services (e.g., anesthesia and imaging) experienced larger decreases than others (e.g., evaluation and management, or E&M). We also looked at whether changes in allowed charges were concentrated in particular areas of the country or age groups, but we found that by April the declines were generally consistent among different geographic regions, urban and rural areas, and age groups. In May 2020, total allowed charges started returning to historic levels, and by June 2020 allowed charges were only about 5 percent less than in June 2019. However, the change in allowed charges continued to vary by type of service, and the recovery among certain age groups (beneficiaries under age 65 and over age 84) and regions of the country (New England and Mid-Atlantic) lagged behind others.

During the coronavirus public health emergency (PHE), the Congress and CMS temporarily expanded coverage of telehealth services, giving providers broad flexibility to furnish telehealth services to ensure that beneficiaries continue to have access to care and to reduce the risk of exposure to COVID-19. For example, clinicians may bill for telehealth services provided to beneficiaries located in their homes and in urban as well as rural areas; prior to the PHE, Medicare paid for telehealth services only if they were provided to beneficiaries in a clinician's office or a facility in a rural area. (For more information on the telehealth expansions, see Chapter 14.) Clinicians responded to these changes by rapidly adopting telehealth services.

The rapid growth of allowed charges for telehealth services partially offset the sharp drop in allowed charges for in-person PFS services in March and April 2020. Telehealth accounted for 16 percent of total allowed charges for all PFS services in April 2020, compared with 0.1 percent in April 2019. This share declined to 11 percent in May 2020 and 7 percent in June as in-person services began to rebound. Telehealth accounted for a larger share of allowed charges for all E&M visits than it did for all PFS services; for example, telehealth made up 26 percent of allowed charges for all E&M visits in April 2020, compared with 16 percent of allowed charges for all PFS services.

We also examined more highly aggregated but less complete FFS claims data to analyze trends after June 2020. Between June and early December, the volume of total primary care visits (which includes both in-person and telehealth) and elective services such as colonoscopies and total knee replacement remained close to or just below the volume of those services during the same time period in 2019.[4] It is notable that the volume of these services did not decline substantially even though the number of coronavirus cases began to increase rapidly in October.

In this chapter, we recommend a payment rate update for 2022. Because of standard data lags, the most recent complete data we have are from 2019 for most payment adequacy indicators. We use these data to make payment recommendations for 2022. To the extent the effects of the coronavirus pandemic are temporary or vary significantly across clinicians, they are best addressed through targeted temporary funding policies rather than a permanent change to all clinicians' payment rates in 2022 and future years. (For an overview of how our payment adequacy analysis takes account of the pandemic, see Chapter 2.) ■

their performance, but historically CMS has given much smaller adjustments of less than 2 percent. For example, in 2021, top performance on MIPS measures will yield a 1.79 percent MIPS adjustment, which is comparable with prior years' top MIPS adjustment. In 2021, about a million clinicians will receive additional payments beyond their base Medicare payment rates: About 800,000 will receive a positive MIPS adjustment based on their performance

on measures, and about 200,000 will receive the 5 percent A–APM bonus. A few hundred thousand clinicians will receive no payment adjustment because they are exempt from MIPS (e.g., due to a low volume of Medicare patients). About 3,000 clinicians will receive negative MIPS adjustments, primarily because they failed to report MIPS measure data (Centers for Medicare & Medicaid Services 2020c, Centers for Medicare & Medicaid Services 2018a).

As currently implemented, MACRA creates incentives for clinicians to participate in A–APMs—first through bonuses that are larger than MIPS adjustments, then through differential payment updates. Starting in 2026, Medicare payment rates for clinicians in A–APMs will increase by 0.75 percent per year, while rates for MIPS clinicians will increase only by 0.25 percent per year. Over time, the difference between payment rates for clinicians in A–APMs and MIPS will grow, making nonparticipation in A–APMs increasingly unattractive financially.

Since early 2020, the coronavirus public health emergency (PHE) has had tragic effects on beneficiaries' health.[5] It also has had material effects on providers' patient volume, revenues, and costs. The effects of the pandemic have varied considerably over time, and it is not clear when they will end. In recognition of the disruptive effects the PHE has had on providers' ability to meet program requirements, CMS offered clinicians the option of not reporting results for some or all MIPS measure categories when calculating their eligibility for MIPS adjustments in 2021 and 2022. More details about the impact of the pandemic on clinicians can be found in the text box and throughout this chapter.

Are Medicare fee schedule payments adequate in 2021?

We assess the adequacy of existing payment rates by reviewing beneficiaries' access to care (including beneficiaries' reports of their experience accessing care, growth in the supply of clinicians, and growth in the number of clinician encounters per beneficiary). We also assess the quality of beneficiaries' care (rates of ambulatory care–sensitive (ACS) hospitalizations and emergency department visits and low-value care). Finally, we assess Medicare payments and providers' costs (including growth in Medicare payments per beneficiary, the ratio of private insurance payment rates to Medicare's rates for clinician services, growth in physician compensation from all payers, and the change in input costs for clinician services). Overall, most indicators show no significant change from prior years.

Beneficiaries' access to care

Beneficiaries' access to care is largely comparable with (or in some cases, better than) access for privately insured individuals. Most beneficiaries report no difficulty accessing care, the number of clinicians billing the fee schedule is growing faster than beneficiary enrollment in Medicare, and the number of clinician encounters per beneficiary is growing.

Beneficiaries report relatively good access to care

Overall, findings from the surveys and focus groups we use to assess Medicare beneficiaries' access to care (see text box, p. 102) are consistent with one another and similar to prior years. The vast majority of beneficiaries report being satisfied with their care and not experiencing trouble accessing care. Our 2020 telephone survey found that, although wait times for routine care appointments continue to be experienced by a sizable minority of beneficiaries, there was no statistically significant *increase* this year in the share of beneficiaries who waited longer than they wanted to for appointments or who reported forgoing care, compared with last year—even with the pandemic. This finding may in part be due to the temporary wide-scale availability of telehealth visits during this period. Notwithstanding these generally positive indicators, non-elderly Medicare beneficiaries reported more difficulties accessing care than elderly beneficiaries, Hispanic beneficiaries reported longer waits for appointments, and Black beneficiaries reported more difficulty finding a new specialist than did White beneficiaries.

Medicare beneficiaries' overall satisfaction with care is higher than that of privately insured patients In our 2020 phone survey, a higher share of Medicare beneficiaries reported that they were very or somewhat satisfied with the overall quality of their care (88 percent) compared with privately insured individuals ages 50 to 64 (82 percent) (Figure 4-1, p. 103). Similarly, CMS's Medicare Current Beneficiary Survey (MCBS) found that, in 2018, 93 percent of Medicare beneficiaries were satisfied or very satisfied with the overall quality of the care they received in the past year. Similar shares of beneficiaries in our focus groups rated their Medicare coverage as excellent or good.

Beneficiary surveys and focus groups used to assess access to care

We used three data sources to assess beneficiaries' access to care this year:

- ***Findings from our customary annual telephone survey of approximately 4,000 Medicare beneficiaries ages 65 and over and 4,000 privately insured individuals ages 50 to 64.*** The goal in surveying these two populations is to assess whether any access concerns reported by Medicare beneficiaries are unique to the Medicare population or are part of trends in the broader health care delivery system. This year's survey was fielded from April through October of 2020. Our survey includes beneficiaries in traditional Medicare and Medicare Advantage (MA) since it is difficult to differentiate between these two types of coverage in a brief survey. MA plans often pay providers rates that are comparable with traditional fee-for-service Medicare. This year, we also compare our survey's results with those of the National Institutes of Health–funded Health and Retirement Study (see text box, p. 106).
- ***CMS's 2018 Medicare Current Beneficiary Survey (MCBS), a nationally representative in-person survey that yielded 14,000 Medicare beneficiary responses for our analysis.*** Findings from the MCBS are not as recent as those from the Commission's survey, but the data are more comprehensive. Therefore, we use the MCBS to confirm and supplement the trends we observe in our phone survey. The MCBS's large sample—which includes both elderly and non-elderly beneficiaries—allows us to examine differences between numerous subgroups of beneficiaries.
- ***Virtual focus groups conducted by the Commission in three markets around the country to obtain an in-depth description of beneficiary and provider experiences with the Medicare program.*** This year, we conducted three focus groups of Medicare beneficiaries (in both traditional Medicare and MA) in each of three markets. One of the groups in each market was composed of beneficiaries dually eligible for Medicare and Medicaid. We also conducted three focus groups with clinicians in each location: primary care physicians, specialist physicians, and a mix of primary care and specialist nurse practitioners and physician assistants. ■

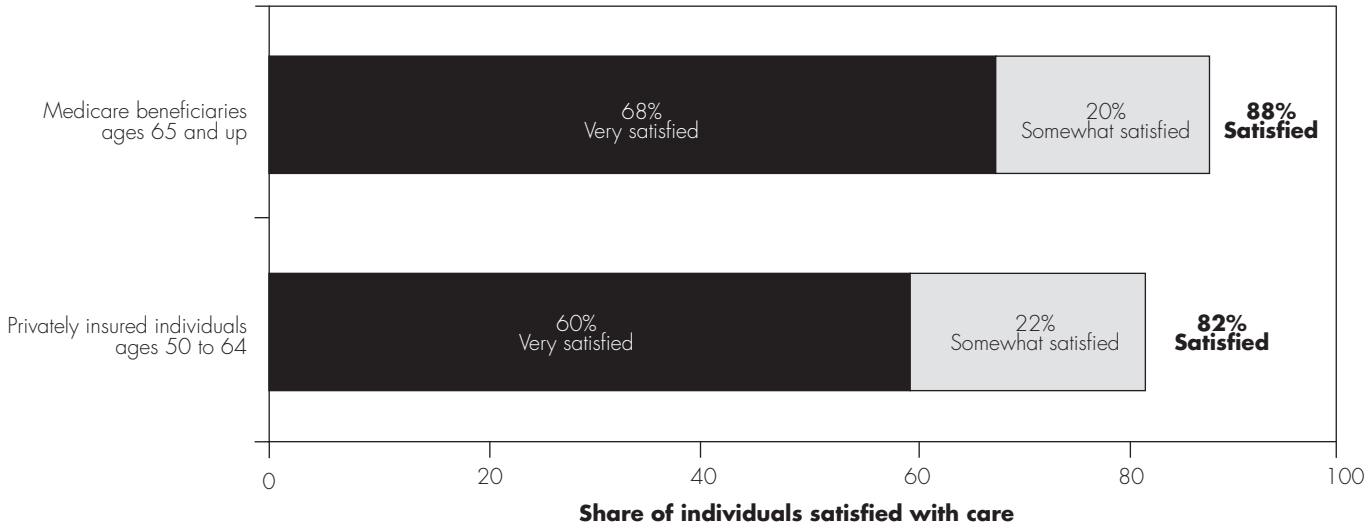
The MCBS found that 93 percent of Medicare beneficiaries reported no trouble accessing care in 2018. Among the 7 percent of beneficiaries who reported trouble, difficulty affording the cost of care was the most commonly cited barrier, mentioned by a third of these respondents (amounting to about 3 percent of all respondents).

In our focus groups, most beneficiaries reported timely access to primary care. Most beneficiaries were able to get appointments with specialists that they needed and did not report encountering any specialties not accepting new patients in their area. However, some beneficiaries mentioned that, when they called a specialist to make an appointment, the wait was longer than they expected.

Beneficiaries maintained good access to care during the pandemic A majority of the beneficiaries in our 2020 phone survey reported that they were able to see a doctor without waiting longer than they wanted (see Table 4A-1 in the appendix to this chapter, p. 125). Among the subset of respondents needing an appointment for routine care, there was no statistically significant difference in the shares of Medicare beneficiaries and privately insured respondents who reported waiting longer than they wanted for this type of care (28 percent vs. 26 percent). Similarly, among those needing an appointment for an *illness or an injury*, identical shares reported waiting longer than they wanted (19 percent). These percentages were not statistically different from those reported last year (i.e., statistically the same).

FIGURE 4–1

More Medicare beneficiaries are satisfied with the overall quality of their health care than privately insured individuals, 2020



Note: Figure does not show the share of respondents who said that they were somewhat dissatisfied, very dissatisfied, did not receive health care in past 12 months, don't know, or refused to answer the question.

Source: MedPAC-sponsored telephone survey, 2020.

Our finding that Medicare beneficiaries were more likely to experience delays getting appointments for routine care than for illnesses or injuries is consistent with other surveys fielded by the Centers for Disease Control and Prevention (CDC) and CMS during the pandemic (Centers for Medicare & Medicaid Services 2020a, Czeisler et al. 2020).

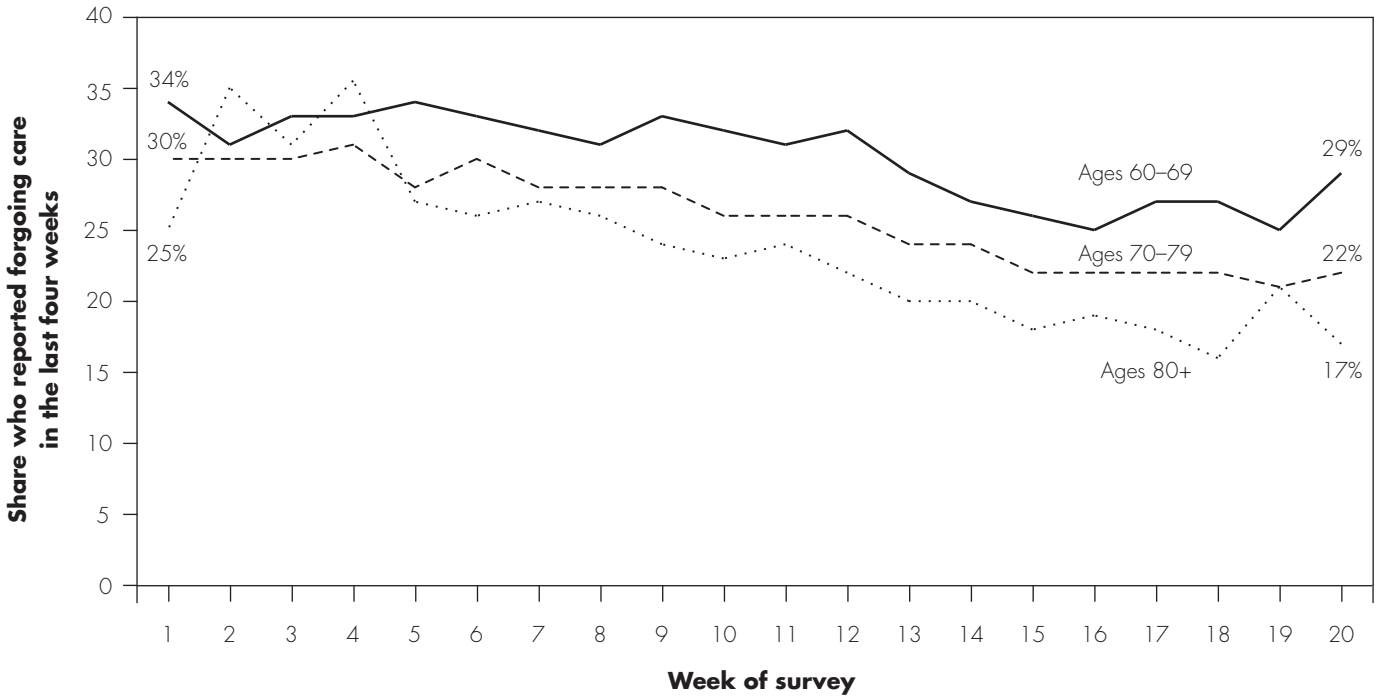
During the coronavirus PHE, the Congress and CMS temporarily expanded coverage of telehealth services (including audio-only telephone services) to ensure that beneficiaries continue to have access to care and to reduce the risk of exposure to COVID-19. (For more information on the telehealth expansions, see Chapter 14.) As a result, many clinicians began to offer care by means of telehealth—either through interactive video calls or audio-only phone calls (Verma 2020).

The Commission's 2020 survey (fielded from April to October) found that 15 percent of Medicare beneficiaries had had a video visit in the past year, and 37 percent had had an audio-only phone visit. In comparison, privately insured individuals were less likely than Medicare beneficiaries to have had an audio-only phone visit (30 percent) and more likely to have had a video visit (18 percent). Medicare beneficiaries' satisfaction with these visits was slightly higher than satisfaction with overall health care: 91 percent of Medicare beneficiaries were satisfied with their video visits and 92 percent were satisfied with their phone visits, while 88 percent were satisfied with their overall health care. Similar trends were observed among the privately insured. However, in our focus groups, beneficiaries who had had a telehealth visit and clinicians who provided these visits generally liked the idea of telehealth, but their reactions to actual visits were mixed. They cited the benefits of increased access and convenience and the challenges of loss of in-person contact and technology issues.

The Commission's survey found that only 10 percent of Medicare beneficiaries reported forgoing care that they thought they should have received in the past year—statistically the same as last year and statistically the same as the share of the privately insured reporting this (see Table 4A-1 in the appendix to this chapter, p. 125). Only 4 percent of each insurance group reported forgoing

FIGURE 4–2

The share of elderly individuals who reported forgoing care in the past four weeks declined from June to December, 2020



Note: "Week 1" refers to April 23–May 5, 2020; "Week 6" refers to June 4–9, 2020; "Week 20" refers to November 25–December 7, 2020. Similar trends were observed for the share reporting *delaying* (as opposed to forgoing) care in the past four weeks.

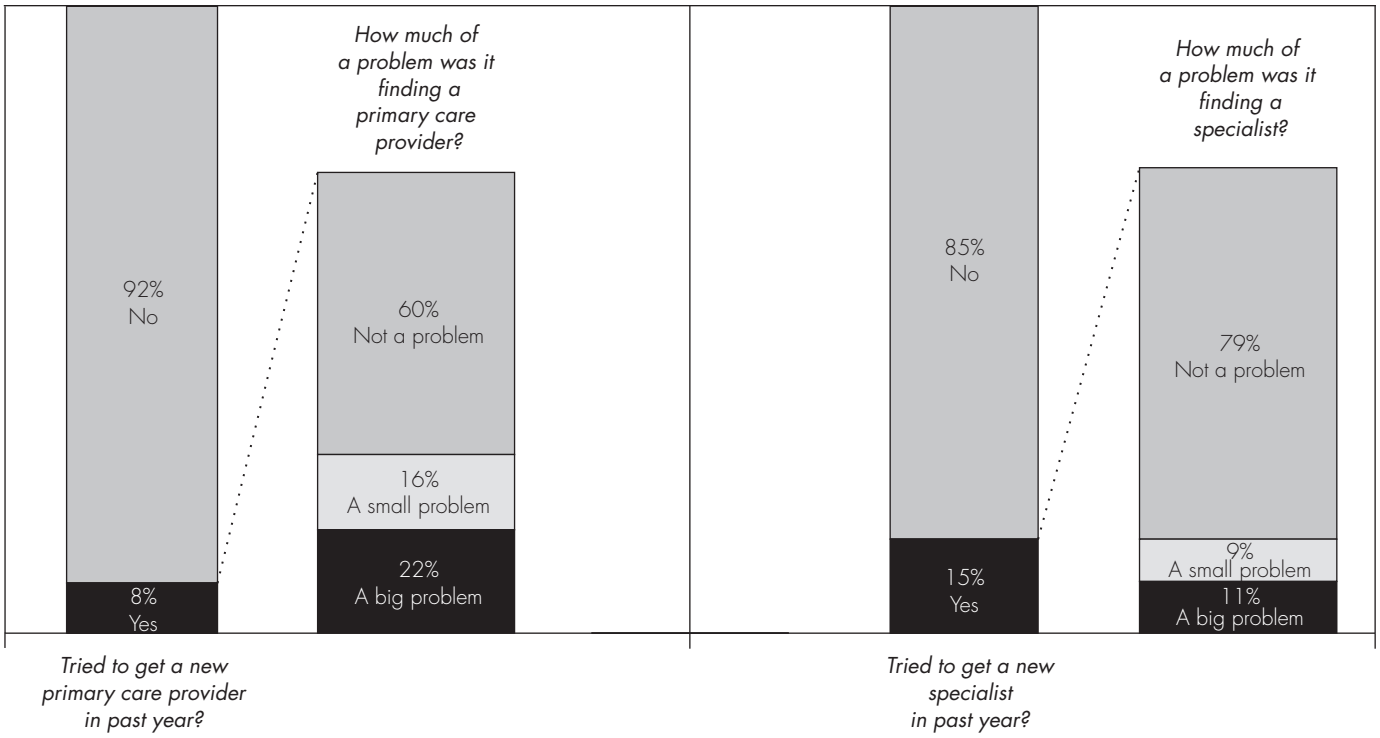
Source: Census Bureau's Household Pulse Survey, fielded 20 times between April 23 and December 7, 2020. (https://www.census.gov/programs-surveys/household-pulse-survey/data.html.)

care specifically because of the pandemic. (Similarly, the CDC survey found that 4 percent of elderly respondents delayed or avoided urgent or emergency care during the pandemic (Czeisler et al. 2020).) In our focus groups, some beneficiaries reported delaying some preventive and routine visits (e.g., colonoscopies and yearly check-ups), and some canceled appointments during the early months of the pandemic. Many said that their appointments had been rescheduled after being canceled earlier in the pandemic or that their clinicians had reopened their offices and were encouraging patients to schedule visits. This finding is consistent with a Census Bureau survey fielded every few weeks during the pandemic, which found several noteworthy trends. First, from April to December, most elderly individuals did not report forgoing or delaying care. Second, the shares of elderly individuals that did report forgoing or delaying care steadily declined from June to early December. Third, older elderly individuals were less likely to forgo or delay care than younger elderly individuals (Figure 4-2) (Census Bureau 2020).

Patients have a harder time finding a new primary care provider than finding a new specialist Nationally, both Medicare beneficiaries and those who are privately insured have an easier time finding a new specialist than finding a new primary care provider. Our telephone survey asks respondents whether, when they are looking for a new doctor, they are able to find one without difficulty. Most beneficiaries reported that they were able to find a new doctor without a problem in 2020. Among the 15 percent

FIGURE 4–3

Medicare beneficiaries' experiences finding a new doctor, 2020



Note: Numbers may not sum to 100 percent because the figure does not show the share of respondents who said they didn't know or refused to answer the question.

Source: MedPAC's annual access-to-care telephone survey, 2020.

of Medicare beneficiaries who looked for a new specialist, 79 percent of this subset reported no problem finding one. In contrast, among the 8 percent who looked for a new primary care provider, only 60 percent reported no problem finding one (Figure 4-3). This pattern of greater difficulty in finding a new primary care provider relative to finding a specialist is consistent with experience in prior years, other surveys, and our beneficiary focus groups, and is also a trend seen among respondents in our survey who are privately insured (data not shown). However, because relatively few individuals were looking for a new clinician and most of those looking reported no problem finding one, the share of respondents who reported a big problem finding a new clinician was very small (1 percent to 2 percent of respondents, depending on the insurance group and the type of clinician) (see Table 4A-1 in the appendix to this chapter, p. 125).

The oldest Medicare beneficiaries have slightly better access to care than younger elderly beneficiaries In our annual phone survey, Medicare beneficiaries ages 65 to 74, 75 to 84, and 85 and over reported similar experiences accessing care, with only a few statistically significant differences between these age cohorts. Beneficiaries ages 85 and older reported better access compared with younger cohorts on two important dimensions. First, smaller shares of beneficiaries ages 85 and over reported being dissatisfied with their care in the past year (2 percent) compared with beneficiaries in the two younger cohorts (5 percent for each of these groups). Second, among beneficiaries ages 85 and over looking for a new primary care provider, only 6 percent had "a big problem" finding a new one (amounting to 0.3 percent of Medicare beneficiaries).

The Commission's survey finds results similar to National Institutes of Health's survey

Each year, the Commission sponsors a telephone survey of about 4,000 Medicare beneficiaries ages 65 and older and about 4,000 privately insured individuals ages 50 to 64. The goal in surveying these two populations is to assess whether any access concerns reported by Medicare beneficiaries are unique to the Medicare population or are part of trends in the broader health care delivery system. This year, to confirm the accuracy of the trends observed in our phone survey, we compared our survey results with those of a larger survey, the Health and Retirement Study (HRS), which is funded by the National Institutes of Health. The HRS is a biennial, longitudinal survey of a representative sample of approximately 20,000 Americans over the age of 50.

Our analysis uses data from 2016 since it is the most recent year of HRS data available that can be weighted to produce nationally representative estimates. In 2016, HRS interviews were conducted either in person or by phone, and like the Commission's survey, interviews were conducted in English or Spanish depending on the respondent's preference. We analyzed HRS responses from about 9,000 Medicare beneficiaries ages 65 and older and about 6,000 privately insured individuals ages 51 to 64.

We analyzed four survey questions that are roughly comparable with each other in these two surveys (shown below in Table 4-2, with differences in question wording noted). We found similar trends in responses to these questions: Both surveys suggest that Medicare beneficiaries' access to care is comparable with, or better than, that of older privately insured individuals. ■

TABLE 4–2

The Commission's telephone survey and the National Institutes of Health's Health and Retirement Study survey produced similar results, 2016

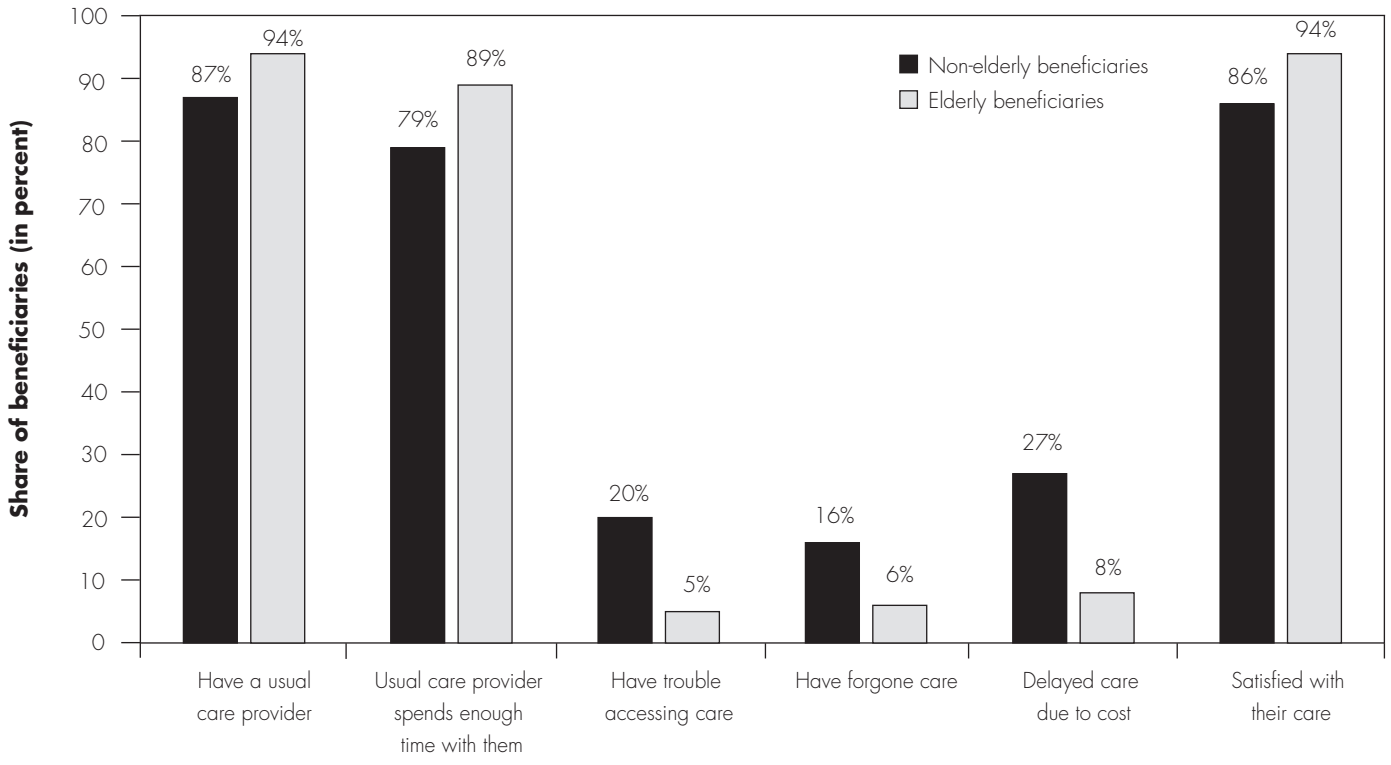
	Medicare beneficiaries ages 65 and older		Privately insured ages 50 or 51 to 64	
	MedPAC survey	NIH survey	MedPAC survey	NIH survey
Satisfied with their health care[a]	86%	86%	80%	77%
Have a usual source of primary care[b]	94	89	91	89
Had trouble finding a primary care provider[c]	3	3	4	3
Needed medical care, but did not get it because could not afford it[d]	1	3	4	6

Note: NIH (National Institutes of Health). Medicare's telephone survey includes about 4,000 Medicare beneficiaries ages 65 and older and about 4,000 privately insured individuals ages 50 to 64. The Health and Retirement Study (HRS) is a biennial, longitudinal survey of a representative sample of approximately 20,000 Americans over age 50. This comparison uses 2016 data because it is the most recent year of HRS data available that can be weighted to produce nationally representative results.
[a]This row compares two related questions in the NIH and MedPAC surveys. The NIH survey question asks: "Thinking about the quality, cost, and convenience of your health care, how satisfied are you overall?" The MedPAC survey question asks: "How satisfied have you been with the overall quality of health care you have received in the past 12 months?"
[b]This row compares two related questions in the NIH and MedPAC surveys. The NIH survey question asks: "Is there a place that you usually go to when you are sick or need advice about your health?" The MedPAC survey asks: "A primary care doctor is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care doctor that you go to for this type of care?"
[c]This row compares two related questions in the NIH and MedPAC surveys. The NIH survey question asks: "In the last two years, did you have any trouble finding a general doctor or provider who would see you?" The MedPAC survey question asks: "How much of a problem was it finding a primary care doctor who would treat you?" (combining the share who reported "a big problem" and "a small problem").
[d]This row compares several related questions in the NIH and MedPAC surveys. The NIH survey question asks: "In the last two years, was there any time when you needed medical care, but did not get it because you couldn't afford it?" The MedPAC question—based on the share of respondents who answered yes to the question "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"—states: "There are different reasons why people do not see a doctor or other medical person about a health problem or condition. Which of these was the main reason you did not see a doctor about this condition during the past 12 months?" with the response option: "You thought it would cost too much."

Source: MedPAC analysis of MedPAC's 2016 access-to-care telephone survey, fielded by SSRS, and the 2016 Health and Retirement Study core public use data set, collected by the University of Michigan, Ann Arbor, MI, with funding from NIH's National Institute on Aging.

FIGURE 4–4

Non-elderly Medicare beneficiaries reported more difficulty accessing care than elderly Medicare beneficiaries, 2018



Note: The vast majority of non-elderly beneficiaries are disabled.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2018.

Non-elderly disabled beneficiaries have more trouble accessing health care due to cost Non-elderly Medicare beneficiaries (most of whom qualify for Medicare because of disability) report noticeably more difficulty accessing care than elderly beneficiaries (Figure 4-4). The 2018 MCBS found that a lower share of these beneficiaries reported having a usual care provider (87 percent) compared with elderly beneficiaries (94 percent). Fewer non-elderly than elderly beneficiaries reported that their usual care provider spent enough time with them (79 percent vs. 89 percent). Even starker differences exist between the shares of non-elderly and elderly beneficiaries who reported trouble accessing care (20 percent vs. 5 percent) and the shares who reported forgoing care that they thought they should have gotten (16 percent of non-elderly vs. 6 percent of elderly). A particularly troubling finding was the substantial share of non-elderly beneficiaries who reported delaying care in the past year due to cost (27 percent) compared with elderly beneficiaries (8 percent). These difficulties could stem from the fact that non-elderly beneficiaries typically have lower incomes than elderly beneficiaries (Jacobson et al. 2017), yet are no more likely to have supplemental insurance than other types of Medicare beneficiaries (Cubanski et al. 2018). As a result, the one in five non-elderly beneficiaries who lack supplemental coverage are likely to have less income available for copayments than elderly beneficiaries who go without supplemental coverage. Given these difficulties, it is perhaps not surprising that lower shares of non-elderly beneficiaries reported being satisfied with their care (86 percent) than did elderly beneficiaries (94 percent).

Similar trends have been found in more recent surveys. A 2020 CDC survey found that respondents with disabilities (regardless of the type of insurance they had) were nearly twice as likely as nondisabled respondents to report delaying or forgoing care because of the pandemic (60 percent vs. 35 percent)—although, like elderly Medicare beneficiaries, they were far more likely to delay or avoid

routine care as opposed to urgent or emergency care (Czeisler et al. 2020).

Hispanic Medicare beneficiaries report longer waits for appointments, and Black Medicare beneficiaries report more problems finding a specialist Our 2020 survey found only a few differences in access to care for different racial and ethnic groups (see Table 4A-2 in the appendix to this chapter, p. 126, which compares White respondents to Black and Hispanic respondents, which we collectively refer to as "Non-White" respondents).

As with prior years, among those needing an appointment for routine care, slightly more non-White than White Medicare beneficiaries reported waiting longer than they wanted for such appointments (31 percent vs. 27 percent). A similar trend was observed for appointments for illnesses or injuries, with 21 percent of non-White beneficiaries experiencing waits compared with 18 percent of White beneficiaries, among those needing such appointments. (Neither of these differences was statistically significant.)

We found no notable differences in the shares of White and non-White beneficiaries who looked for a new primary care provider or a new specialist in the past year or in the shares who reported problems finding new providers. Smaller shares of Black beneficiaries reported looking for a new *specialist* in the past year (9 percent) compared with White beneficiaries (15 percent) and markedly higher shares of Black beneficiaries reported experiencing "a small problem" finding a new specialist compared with White beneficiaries (22 percent vs. 8 percent). A similar, but less pronounced, trend exists among those who are privately insured. There was no difference in the share of White and non-White beneficiaries who reported forgoing care in the past year (10 percent of each group).

Among those beneficiaries seeking an appointment for care, higher shares of Hispanic beneficiaries reported waiting longer than they wanted, compared with White beneficiaries, to get appointments for routine care (35 percent vs. 27 percent) and to get appointments for illnesses and injuries (24 percent vs. 18 percent). Given these trends, it is perhaps not surprising that lower shares of Hispanic beneficiaries reported being satisfied with their health care compared with White beneficiaries (83 percent vs. 89 percent) (data not shown). The same trend was observed among those who were privately insured.

The 2018 MCBS also allows examination of access-to-care trends by race and ethnicity. According to this survey, the majority (usually 90 percent or more) of racial and ethnic subgroups reported that they had a usual source of care, the clinician they normally saw spent enough time with them, they had no trouble accessing care, they did not forgo care they thought they should have gotten, and they were satisfied with the quality of their health care. There were some small differences in the shares that reported delaying care due to cost: 13 percent of Black beneficiaries reported delaying care, compared with 11 percent of Hispanic beneficiaries, 10 percent of White beneficiaries, and 7 percent of Asian beneficiaries.

Rural beneficiaries have access to care similar to urban beneficiaries, but report slightly different care patterns The Commission's telephone survey usually finds no substantive differences in access to care for urban and rural Medicare beneficiaries. In keeping with that trend, the share of beneficiaries in rural and urban areas who reported waiting longer than they wanted for an appointment was statistically the same this year—both for routine care and for illness or injury care (see Table 4A-3 in the appendix to this chapter, p. 127). There was also no statistical difference between the share of urban and rural beneficiaries who reported forgoing care they thought they should have gotten in the past year.

Some new trends emerged this year, however. First, slightly lower shares of rural Medicare beneficiaries reported being satisfied with the quality of their health care (85 percent) than urban beneficiaries (89 percent)—though these rates are both relatively high. Second, more rural beneficiaries reported not seeing any specialists in the past year (37 percent) compared with urban beneficiaries (31 percent). This divergence was also observed in 2016, but the trends for seeing specialists returned to similar levels in subsequent years.

Other 2020 survey trends were in keeping with prior years, such as the higher share of rural beneficiaries who reported getting most or all of their care from a nurse practitioner or physician assistant (26 percent) compared with urban beneficiaries (19 percent).

The 2018 MCBS survey found no substantive differences between urban and rural beneficiaries' access to care, including identical rates of satisfaction with care (93 percent), trouble accessing care (7 percent), and forgoing care (7 percent).

Nearly all Medicare beneficiaries have a regular source of care In 2020, nearly all beneficiaries (94 percent) in the Commission's telephone survey reported that they had a regular source of primary care. This finding is consistent

TABLE 4–3

The number of clinicians billing under the fee schedule increased, but the mix of clinicians changed, 2014–2019

	Number (in thousands)					Number per 1,000 beneficiaries				
	Physicians					Physicians				
Year	Primary care specialties	Other specialties	APRNs and PAs	Other practitioners	Total	Primary care specialties	Other specialties	APRNs and PAs	Other practitioners	Total
2014	141	432	161	156	890	2.9	8.8	3.2	3.2	18.0
2015	141	439	178	161	919	2.8	8.7	3.5	3.2	18.1
2016	141	447	198	167	952	2.7	8.6	3.8	3.2	18.3
2017	140	455	218	172	985	2.6	8.5	4.1	3.2	18.4
2018	139	461	237	178	1,015	2.5	8.4	4.3	3.2	18.5
2019	139	468	258	184	1,048	2.5	8.3	4.6	3.3	18.7

Note: APRN (advanced practice registered nurse), PA (physician assistant). "Primary care specialties" include family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists. Hospitalists are counted in "other specialties." "Other practitioners" include clinicians such as physical therapists, psychologists, social workers, and podiatrists. The number of clinicians shown in this table includes only those with a caseload of more than 15 beneficiaries in the year. Beneficiary counts used to calculate clinicians per 1,000 beneficiaries include those enrolled in traditional Medicare Part B and those in Medicare Advantage, based on the assumption that clinicians generally furnish services to beneficiaries in both programs. Numbers exclude nonperson providers such as clinical laboratories and independent diagnostic testing facilities. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and 2020 annual report of the Boards of Trustees of the Medicare trust funds.

with the MCBS data: 93 percent of beneficiaries reported having a usual source of care in 2018. Among Medicare beneficiaries with a usual source of care, the MCBS found that the vast majority used appropriate care settings as their usual source of care: Only 1 percent used a hospital emergency room or an urgent care clinic as their usual source of care in 2018. The MCBS also found that 94 percent of respondents with a usual care provider felt this provider spent enough time with them.

In our beneficiary focus groups, nearly all beneficiaries reported a regular source of primary care, including physicians, nurse practitioners (NPs), or physician assistants (PAs). In the Commission's telephone survey, 53 percent of beneficiaries responded that they saw an NP or PA for some, most, or all of their primary care—comparable with the 53 percent of privately insured respondents who reported this same response.

Growth in the supply of clinicians billing Medicare has outpaced enrollment growth, but the mix of clinicians is changing

From 2014 to 2019, the number of clinicians billing the fee schedule grew faster than the Medicare population. However, the mix of clinicians has changed over time.

We limited this part of our analysis of clinicians to those who billed for more than 15 beneficiaries in a given year. This minimum threshold helps us (1) better measure clinicians who substantially participate in Medicare and are therefore likely critical to ensuring beneficiary access to care and (2) avoid year-to-year variability in clinician counts (i.e., excludes physicians who billed for one or two beneficiaries in one year but may not have billed for any beneficiaries the following year).[6]

Using the 15-beneficiary threshold, we found that the number of clinicians billing the fee schedule between 2014 and 2019 grew from about 890,000 to 1,048,000 (Table 4-3). Over the same period, the total number of clinicians per 1,000 beneficiaries increased from 18.0 to 18.7.[7]

While the number of clinicians billing the fee schedule has increased, trends varied by type and specialty of clinicians. The number of primary care physicians billing the fee schedule held steady from 2014 to 2016 but declined modestly from 2016 to 2019. On net, these changes resulted in about 2,500 fewer primary care physicians billing the fee schedule in 2019 compared with 2014.

TABLE 4–4

Total encounters per beneficiary increased but mix of clinicians furnishing them changed from 2014 to 2019

	Encounters per beneficiary			Percent change in encounters per beneficiary	
Specialty category	2014	2018	2019	Average annual (2014–2018)	2018–2019
Total (all clinicians)	20.8	21.7	22.2	1.1%	2.1%
Primary care physicians	3.9	3.6	3.5	–2.4	–2.3
Specialists	12.6	12.7	12.9	0.3	1.1
APRNs/PAs	1.4	2.2	2.5	11.6	10.9
Other practitioners	2.9	3.3	3.4	2.8	4.9

Note: APRN (advanced practice registered nurse), PA (physician assistant). We define "encounters" as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and national provider identifiers of the clinicians who billed for the service. Numbers do not account for "incident to" billing, meaning, for example, that encounters with APRNs/PAs that are billed under Medicare's "incident to" rules are included in the physician totals. We use the number of fee-for-service Medicare beneficiaries enrolled in Part B to define encounters per beneficiary. Components may not sum to totals due to rounding, and percent change columns were calculated on unrounded data.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and 2020 annual report of the Boards of Trustees of the Medicare trust funds.

In contrast, the number of advanced practice registered nurses (APRNs) and PAs billing the fee schedule increased rapidly; from 2014 to 2019, the number of APRNs and PAs grew from about 161,000 to 258,000.[8] The number of specialist physicians and other practitioners, such as physical therapists and podiatrists, who billed the fee schedule increased modestly.

Most clinicians who bill Medicare are participating providers

In 2019, 97 percent of clinicians billing the fee schedule were participating providers. Participating providers agree to take assignment for all claims, which means that they accept the fee schedule amount (which includes Medicare's payment plus beneficiary cost sharing) as payment in full. Nonparticipating providers can choose whether to take assignment for their claims on a claim-by-claim basis. Nonparticipating providers who take assignment on a claim receive 95 percent of the fee schedule amount. Nonparticipating providers who do not take assignment on a claim may "balance bill" beneficiaries up to 109.25 percent of the fee schedule amount for participating providers.[9] While balance billing is allowed, clinicians rarely balance bill beneficiaries for fee schedule services; in 2019, 99.6 percent of fee schedule claims were paid on assignment.

Clinicians can also sign up as an opt-out provider if they wish to bill beneficiaries for services directly, outside of the Medicare benefit. The 26,000 clinicians who chose to opt out of Medicare as of October 2020 were concentrated in the specialties of behavioral health (41 percent),[10] oral health (29 percent),[11] and primary care (11 percent)[12] (Centers for Medicare & Medicaid Services 2018b). The number of clinicians who opted out in 2020 was comparable with the number in 2019.

Total number of clinician encounters per beneficiary grew faster from 2018 to 2019 than in recent years

We use encounters between beneficiaries and clinicians as another measure of access to care. Encounters are a measure of entry into the health care system. Entry can be a first step toward timely use of services (Office of Disease Prevention and Health Promotion 2019).

We use a claims-based definition of encounters.[13] Clinicians submit a claim when they furnish one or more services to a beneficiary in traditional Medicare. For example, if a physician billed for an evaluation and management (E&M) visit and an X-ray on the same claim, we would count that as one encounter. About 98 percent of

beneficiaries enrolled in traditional Medicare had at least one encounter in 2019.[14]

We found that the number of encounters per traditional Medicare beneficiary increased modestly over time, with faster growth from 2018 to 2019 than in recent years. Specifically, from 2014 to 2018, the number of total encounters per beneficiary increased from 20.8 to 21.7, an average annual increase of 1.1 percent (Table 4-4). From 2018 to 2019, the number of encounters per beneficiary increased from 21.7 to 22.2, an increase of 2.1 percent. Preliminary claims data during the first six months of 2020 indicate that, in March and April, the total number of encounters declined sharply in response to the coronavirus pandemic, but had largely recovered by June. More recent but less complete claims data indicate that the volume of primary care visits and certain elective procedures remained fairly constant from June through early December, despite the rising number of coronavirus cases.

Growth in the number of encounters per beneficiary varied by specialty and type of provider From 2018 to 2019, the number of encounters per beneficiary with primary care physicians declined by about 2.3 percent (Table 4-4). Over the same period, the number of encounters per beneficiary with APRNs or PAs increased by about 10.9 percent, the number of encounters with specialist physicians (who account for a majority of all encounters) increased slowly (1.1 percent), and encounters with other clinicians (e.g., physical therapists) increased moderately (4.9 percent). The changes from 2018 to 2019 are part of a longer-term trend. For example, from 2014 to 2018, we also found declines in encounters per beneficiary with primary care physicians, rapid growth in encounters with APRNs or PAs, and slow or moderate growth in encounters with all other clinicians.

The decline in beneficiary encounters with primary care physicians occurred across a broad range of services. For example, from 2014 to 2019, the average annual change in the number of encounters per beneficiary with primary care physicians for E&M services, other procedures, imaging services, and tests was –2.4 percent, –3 percent, –3.4 percent, and –5.1 percent, respectively (data not shown).[15]

Not only did beneficiaries have fewer encounters with primary care physicians, but the number of beneficiaries with at least one primary care physician encounter also declined during the year. From 2014 to 2019, the total number of primary care physician encounters decreased by more than 11 percent, whereas the number of beneficiaries who had at least one encounter with a primary care physician fell by only 4 percent (data not shown).

Recent research has documented that similar decreases in encounters with primary care physicians have occurred among the privately insured population (Ganguli et al. 2019). This trend suggests that primary care physicians are not filling their patient panels with privately insured patients in lieu of Medicare beneficiaries. Rather, the consistent declines across patient populations suggest that systematic changes in the delivery of primary care are occurring.

The rapid growth in encounters with APRNs and PAs raises questions about whether they are replacing services that were once provided by primary care physicians. Using claims data, we are unable to determine whether APRNs and PAs work in primary care practices or specialist practices. Therefore, the Commission has recommended that the Secretary collect more detailed information on the specialties in which APRNs and PAs practice (Medicare Payment Advisory Commission 2019). Studies published between 2011 and 2019 estimate that about half of nurse practitioners (the largest subgroup of APRNs) and one-quarter of PAs work in primary care, although these practice patterns might have changed since then (Agency for Healthcare Research and Quality 2011, Health Resources & Services Administration 2014, National Commission on Certification of Physician Assistants 2019). While these studies suggest that only a portion of APRNs and PAs work in primary care, our analysis found that the decline in beneficiary encounters with primary care physicians coincided with a dramatic rise in encounters with APRNs or PAs, suggesting that these clinicians may be furnishing at least some services once performed by primary care physicians. These findings could also help explain why the Commission's annual telephone survey has not found a decline in the share of beneficiaries with a primary care provider in recent years (94 percent), even though our claims analysis finds that encounters with primary care physicians have declined substantially; beneficiaries are still able to access primary care, but different clinicians may be furnishing it.

Encounters per beneficiary grew across service types Examining beneficiary encounters by service type, we found that encounters grew modestly, with some differences across categories. From 2018 to 2019, the number of E&M encounters per beneficiary provided

TABLE 4–5 **Encounters grew modestly across all service types, 2014–2019**

Type of service	Encounters per beneficiary			Percent change in encounters per beneficiary	
	2014	2018	2019	Average annual (2014–2018)	2018–2019
Total (all services)	20.8	21.7	22.2	1.1%	2.1%
Evaluation and management	12.4	12.9	13.1	1.1	1.4
Major procedures	0.2	0.2	0.2	0.8	1.7
Other procedures	4.2	4.6	4.8	2.2	4.2
Imaging	3.9	4.0	4.1	0.8	2.0
Tests	2.1	2.1	2.2	0.6	2.0
Anesthesia	0.5	0.5	0.6	3.6	2.5

Note: We define "encounters" as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and national provider identifiers of the clinicians who billed for the service. We use the number of fee-for-service Medicare beneficiaries enrolled in Part B to define encounters per beneficiary. Values by type of service do not sum to totals because encounters with multiple service types are counted separately for each type of service but counted only once for the total. For example, if an imaging service and a test were billed in the same encounter, we count that as one encounter for imaging and one for tests (for a total of two encounters), but we count the services as one encounter for the total row. All numbers in the table are rounded, but unrounded data are used for calculations.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and 2019 annual report of the Boards of Trustees of the Medicare trust funds.

by all clinicians rose most slowly, by 1.4 percent, from 12.9 to 13.1 (Table 4-5). Over the same period, major procedure encounters grew slightly more (1.7 percent), and encounters involving a procedure other than a major procedure (i.e., "other procedures") grew most rapidly (4.2 percent). Other procedures include skin procedures and various forms of outpatient therapy (physical therapy, occupational therapy, and speech–language pathology). With the exception of anesthesia services, growth in encounters per beneficiary from 2018 to 2019 was similar to or faster than the average annual growth rates from 2014 to 2018.

We also examined how the number of encounters billed in traditional Medicare changed during the early months of the coronavirus pandemic. Based on our analysis of preliminary Medicare claims data for the first six months of 2020, we found that changes in the total number of encounters for clinician services was largely consistent with the pattern we observed in allowed charges (see text box about the effects of the coronavirus pandemic, p. 100). Encounters dropped sharply starting in March 2020, and by April 2020 the total number of encounters was about half of its level in April 2019. As with allowed charges, there is variation in how much encounters declined among different types of services, with E&M encounters dropping less than other services. By June 2020, encounters for all services were about 6 percent less than what they were in June 2019.

Quality of care

We assessed the quality of the ambulatory care environment for traditional Medicare beneficiaries using outcome measures assessing ambulatory care–sensitive (ACS) hospitalizations, emergency department (ED) visits, and measures of low-value care. (In this year's assessment, we were not able to report on the patient experience of traditional Medicare beneficiaries during the 2019 calendar year because CMS halted collection of the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey at the start of the pandemic.[16]) This approach is consistent with the Commission's principle that Medicare's quality incentive programs should use a small set of population-based outcome, patient experience, and value measures to assess the quality of care across different populations, such as

beneficiaries enrolled in Medicare Advantage (MA) plans, traditional Medicare, and accountable care organizations (ACOs) in defined market areas as well as those cared for by particular hospitals, groups of clinicians, and other providers (Medicare Payment Advisory Commission 2018a).

By contrast, CMS measures the performance of clinicians using the Merit-based Incentive Payment System (MIPS). The basic design principle of MIPS is that clinician quality of care and payment adjustments for quality can and should be determined primarily at the individual clinician level, based on measures that clinicians themselves choose to report. But a system built on this design is inequitable because clinicians are evaluated and compared on dissimilar measures. The majority of the measures focus on processes of care as opposed to patient outcomes, and many have compressed performance (i.e., "topped out," which means that all clinicians are performing well on the measure). In addition, many clinicians are not evaluated at all because, as individuals, they do not have a sufficient number of cases for statistically reliable scores. Further, the design is at odds with the fact that quality outcomes for patients—the principal objective of any value improvement program—are determined primarily through the combined efforts of many providers rather than by the actions of any one clinician.

For these reasons, in March 2018, the Commission recommended eliminating MIPS. In MIPS's place, we recommended a voluntary value program, through which groups of clinicians would receive increases or decreases to their payment rates based on their performance on a uniform set of measures assessing outcomes, patient experience, and value (Medicare Payment Advisory Commission 2018b).

Measures of ambulatory care–sensitive hospitalizations and emergency department visits signal opportunities for improvement

The Commission developed two claims-based outcome measures—ACS hospitalizations and ED visits—to compare quality of care within and across different populations (i.e., traditional Medicare in different local market areas), given the adverse impact on beneficiaries and high cost of these events. Conceptually, an ACS hospitalization or ED visit refers to hospital use that could have been prevented with appropriate, high-quality, and timely care in ambulatory care settings. Two categories of ACS conditions are included in the measures: chronic (e.g., diabetes, asthma, hypertension) and acute (e.g., bacterial pneumonia, cellulitis). Although payers often examine total hospital utilization or measures of total spending in cost containment efforts, identification of potentially avoidable hospital admissions or ED visits for ACS conditions can offer more useful insights into a market area's quality of care and may inform quality improvement initiatives in Medicare.

We continue to find wide variation in the distribution of risk-standardized rates of avoidable hospitalizations and ED visits per 1,000 traditional Medicare beneficiaries across Dartmouth-defined hospital service areas (HSAs), which signals opportunities to improve the quality of ambulatory care (Table 4-6, p. 114).[17] The HSA at the 90th percentile of ACS hospitalizations had a rate that was 1.9 times the HSA at the 10th percentile. The HSA at the 90th percentile of ACS ED visits had a rate that was 2.4 times the HSA in the 10th percentile. Relatively poor performance on a local market's ACS hospitalization and ED visit measures can identify opportunities for improvement in those ambulatory care systems, while relatively good performance on the measures can identify best practices for ambulatory care systems.

Substantial use of low-value care in traditional Medicare

We also calculated rates of low-value care in traditional Medicare, which is another indicator of ambulatory care quality. Low-value care is the provision of a service that has little or no clinical benefit or care in which the risk of harm from the service outweighs its potential benefit (Chan et al. 2013, Kale et al. 2013). In addition to increasing health care spending, low-value care has the potential to harm patients by exposing them to risks of injury from inappropriate tests or procedures and can lead to a cascade of additional services (Keyhani et al. 2013, Korenstein et al. 2012). The "Choosing Wisely" campaign, an initiative of the American Board of Internal Medicine Foundation, identifies low-value services. Thus far, more than 80 specialty societies have identified over 550 tests and treatments that are often overused (ABIM Foundation 2020).

A team of researchers developed 31 measures of low-value care drawn from evidence-based lists (such as Choosing Wisely), recommendations by the U.S. Preventive Services Task Force, and the medical literature, which the team applied to Medicare claims data from 2009 to 2012 (Schwartz et al. 2015, Schwartz et al. 2014).

TABLE 4–6 **Distribution of risk-standardized rates of ambulatory care–sensitive hospitalizations and ED visits across hospital service areas signals opportunities for improvement, 2019**

	Risk-standardized rate per 1,000 FFS beneficiaries			
	10th percentile (high performing)	50th percentile	90th percentile (low performing)	Ratio of 90th to 10th percentile
Ambulatory care–sensitive hospitalizations	35.1	48.9	66.6	**1.9**
Ambulatory care–sensitive ED visits	62.4	98.6	150.0	**2.4**

Note: ED (emergency department), FFS (fee-for-service). Lower rates are better. To measure population-based outcomes for FFS Medicare beneficiaries, we calculated the risk-standardized rates of admissions and ED visits tied to a set of acute and chronic conditions per 1,000 FFS Medicare beneficiaries in hospital service areas (HSAs). There are about 3,400 Dartmouth-defined HSAs. The average population of FFS Medicare beneficiaries in each HSA is about 10,000 beneficiaries. We excluded any HSA with fewer than 1,000 FFS Medicare beneficiaries.

Source: Analysis of 2019 Medicare FFS claims data.

For more detail about these measures and our previous analysis of low-value care, see the Commission's June 2018 report to the Congress (Medicare Payment Advisory Commission 2018a). We updated our analysis by applying the measures' algorithms to Medicare claims data from all providers for 2018. Similar to our previous analysis, we calculated two versions of each measure: a broader version (more sensitive, less specific) and a narrower version (less sensitive, more specific).[18] For each version, we calculated the number of low-value services per 100 traditional Medicare beneficiaries, the share of beneficiaries who received at least one low-value service, and total spending across all beneficiaries for each service.

Our results show substantial use of low-value care in traditional Medicare in 2018 (Table 4-7). Based on the broader versions of the measures (which may misclassify some appropriate care as inappropriate), our analysis found 70 instances of low-value care per 100 beneficiaries, with 36 percent of beneficiaries receiving at least one low-value service. We estimate that Medicare spending for these services was $6.9 billion, or 1.9 percent of traditional Medicare spending. Based on the narrower, more conservative versions of the measures (which may miss some instances of inappropriate care), our analysis showed 33 instances of low-value care per 100 beneficiaries, with 22 percent of beneficiaries receiving at least one low-value service. We estimate that Medicare spending for these services totaled $2.4 billion, or 0.6 percent of traditional Medicare spending. Between 2016 and 2018, there was a modest decline in the volume of, and spending on, low-value services based on the narrower versions of the measures, but there was no change based on the broader versions of the measures (data not shown).

Using the broader versions of the measures, low-value services with the highest volume in 2018 were imaging for patients with nonspecific low back pain (12.6 per 100 beneficiaries), prostate-specific antigen (PSA) screening for men ages 75 and over (8.7), and colon cancer screening for adults older than age 85 (6.9). Low-value services with the highest Medicare spending were percutaneous coronary intervention (PCI) with balloon angioplasty or stent placement for stable coronary disease ($1.4 billion), spinal injection for low back pain ($1.4 billion), and stress testing for stable coronary disease ($1.1 billion).

Using the narrower versions of the measures, low-value services with the highest volume in 2018 were PSA screening for men ages 75 and over (4.9 per 100 beneficiaries), parathyroid hormone measurement for patients with early chronic kidney disease (4.6), and total or T3 level testing for patients with hypothyroidism (4.3). Those with the highest Medicare spending were spinal injection for low back pain ($633 million), vertebroplasty or kyphoplasty for osteoporotic vertebral fractures ($328 million), and PCI with balloon angioplasty or stent placement for stable coronary disease ($254 million).

TABLE 4–7

Between 33 and 70 low-value services were provided per 100 beneficiaries in 2018; Medicare spent between $2.4 billion and $6.9 billion on these services

	Count per 100 beneficiaries	Share of beneficiaries affected	Spending (in billions)
Broader measures	70	36	**$6.9**
Narrower measures	33	22	**$2.4**

Note: "Count" refers to the number of unique services provided to beneficiaries in traditional Medicare. "Spending" includes Medicare Part A and Part B program spending and beneficiary cost sharing for services detected by measures of low-value care. Spending is based on a standardized price for each service from 2009 that was updated to 2018. The broader measures are more sensitive and less specific, while the narrower measures are less sensitive and more specific. Increasing the sensitivity of a measure captures more potentially inappropriate use but is also more likely to misclassify some appropriate use as inappropriate. Increasing a measure's specificity leads to less misclassification of appropriate use as inappropriate, at the expense of potentially missing some instances of inappropriate use.

Source: MedPAC analysis of 100 percent of Medicare claims using measures developed by Schwartz and colleagues (Schwartz et al. 2015, Schwartz et al. 2014).

Our analysis likely represents a conservative estimate of the number and cost of low-value services in Medicare. The measures of low-value services we used exclude many services that Choosing Wisely and other clinicians may consider low value (e.g., imaging for pulmonary embolism without moderate or high pretest probability) because it was difficult to distinguish between inappropriate and appropriate use of these services with claims data (Schwartz et al. 2014). In addition, we did not estimate the downstream cost of low-value services because of the difficulty in determining whether a specific low-value service led directly to a downstream service (e.g., a follow-up test or procedure). A literature review of five low-value services suggests that downstream service use and spending related to these services is substantial (Chang et al. 2019). For example, one study estimated that the mean cost per patient of downstream services related to imaging for nonspecific low back pain was more than $23,000 over two years (Webster et al. 2013).

Medicare payments and providers' costs

To assess Medicare payments, we examine growth in traditional Medicare-allowed charges (i.e., payments to providers, including beneficiary cost sharing) for fee schedule services. We also consider how private insurance rates paid by preferred provider organizations (PPOs) for clinician services compare with Medicare's rates. In addition, we examine growth in all-payer physician compensation and compare compensation across specialties. Because clinicians do not report their costs to CMS, we assess the change in input prices for clinician services using the Medicare Economic Index (MEI).

Overall, Medicare's payments to clinicians, as well as overall physician compensation, are climbing faster than input costs. We found that allowed charges per beneficiary for clinician services between 2018 and 2019 grew 3.7 percent, a higher growth rate than in prior years. In 2019, private PPO payment rates were 136 percent of traditional Medicare rates for clinician services, compared with 135 percent in 2018. From 2015 to 2019, median physician compensation from all payers grew by 3.3 percent per year, on average, but median compensation in 2019 remains much lower for primary care physicians than for physicians in certain other specialties, such as radiology and surgical specialties. Meanwhile, the MEI increased by 1.5 percent in 2019, and CMS projects that it will increase by 1.6 percent in 2022.

Allowed charges grew faster from 2018 to 2019 than in recent years

Allowed charges are the total payments a provider receives (including beneficiary cost sharing) from providing fee schedule services to beneficiaries enrolled in traditional Medicare. Allowed charges are a function of the fee schedule's relative value units (RVUs), the fee schedule's conversion factor, and other payment adjustments, such as those determined by geographic practice cost indexes.

We used claims data from 2014, 2018, and 2019 to analyze changes in allowed charges for the services

furnished by clinicians billing under Medicare's fee schedule. We grouped individual service codes into broad service categories that are clinically meaningful (e.g., E&M, major procedures). Each broad service category contains multiple subcategories of similar services (e.g., E&M includes office/outpatient services, hospital inpatient services, and other subcategories).

We also present changes in units of service per beneficiary. A difference between a change in allowed charges and a change in units of service means that a factor other than volume is affecting the amount of allowed charges being generated. For example, if providers substitute higher-RVU computed tomography scans for lower-RVU X-rays, the allowed charges for imaging services would increase at a higher rate than would units of service for imaging. However, we recommend caution in interpreting such data. Decreases in allowed charges could be related to the movement of services from freestanding offices to hospitals (see text box on shifts in billing, p. 118).

Between 2018 and 2019, across all services, allowed charges per beneficiary grew by 3.7 percent (Table 4-8). Among broad service categories, growth rates were 2.9 percent for E&M services, 3.5 percent for imaging services, 5.1 percent for major procedures, 5.6 percent for other procedures, 2.9 percent for tests, and 2.6 percent for anesthesia services. Growth in allowed charges per beneficiary from 2018 to 2019 was faster than the average annual growth rates from 2014 to 2018 for all services (combined) and for each broad service category.

Within broad service categories, services for some subcategories experienced more rapid growth in allowed charges per beneficiary. For example, from 2018 to 2019, growth in the other procedures category was 5.6 percent, but growth in the subcategory of physical, occupational, and speech therapy was 12.9 percent.

From 2018 to 2019, among the service categories, vascular major procedures had the highest rate of growth in allowed charges per beneficiary at 14.4 percent. This growth was largely driven by procedures categorized as revascularization of the lower extremity (used to treat leg pain caused by poor circulation). Allowed charges for these procedures increased by 24.1 percent (data not shown). Most of this growth was concentrated in the three most frequently billed revascularization procedures, where the number of units of service increased by between 6.4 percent and 13.9 percent, and RVUs increased by between 6.3 percent and 13.3 percent (data not shown). Although vascular major procedures experienced high growth, they accounted for 1.5 percent of total fee schedule spending in 2019.

Physical, occupational, and speech therapy is another service category with a high growth rate. Allowed charges per beneficiary within this category grew between 2014 and 2018 by an average of 8.3 percent and from 2018 to 2019 by 12.9 percent. Payment rates during these periods were largely constant; the growth in allowed charges was driven almost entirely by increases in the volume of therapy services. From 2018 to 2019, total units of service per beneficiary increased by 11.8 percent, which was driven by volume growth among a small number of therapy services.

From 2018 to 2019, a few types of services experienced decreases in allowed charges. For example, the largest decrease (8.3 percent) was for nononcologic injections and infusions. This decrease occurred despite a 1.4 percent increase in units of service delivered per year. The difference is explained by a 19 percent decrease in RVUs implemented in 2019 for the most frequently billed service (which includes certain therapeutic, prophylactic, and diagnostic injections and infusions) in this category (data not shown).

To gauge the impact of the coronavirus pandemic, we used preliminary claims data to examine changes in Medicare's payments to clinicians during the first six months of 2020. We found that allowed charges for clinician services dropped sharply starting in March 2020. By April 2020, total allowed charges were roughly half what they were in April 2019. In May 2020, allowed charges began to recover, and, by June 2020, they were only about 5 percent less than in June 2019 (see text box on the effect of the pandemic, p. 100). Similarly, clinicians' revenue for privately insured patients declined sharply at the beginning of the pandemic before rebounding. According to an analysis by FAIR Health of its national private insurance claims database (which includes Medicare Advantage claims), clinician revenue was 45 percent lower in March 2020 than in March 2019 (FAIR Health 2020). Revenues began to recover in May and were higher than the prior year starting in July. By October (the most recent month of data available), revenues were 20 percent higher than the prior year. These results suggest that patients' higher-than-usual demand for services in the summer and fall of 2020 helped offset the temporary revenue drop experienced by clinicians during the first few months of the pandemic.

TABLE 4–8

Allowed charges per beneficiary continued to grow, 2014–2019

Type of service	Change in units of service per beneficiary		Change in allowed charges per beneficiary		Share of 2019 allowed charges
	Average annual 2014–2018	2018–2019	Average annual 2014–2018	2018–2019	
All services	**1.1%**	**3.1%**	**1.3%**	**3.7%**	**100.0%**
Evaluation and management	**0.7**	**1.5**	**1.3**	**2.9**	**50.0**
Office/outpatient services	0.8	1.3	1.5	3.4	25.6
Hospital inpatient services	–1.3	–0.3	–0.6	0.5	10.5
Nursing facility services	1.0	4.2	1.8	5.1	3.0
Emergency department services	–0.3	–1.7	0.5	–0.6	2.9
Ophthalmological services	0.3	1.4	0.9	3.1	2.7
Behavioral health services	2.4	4.3	3.0	5.7	1.9
Critical care services	2.0	3.7	2.0	3.6	1.4
Care management/coordination	32.5	11.2	31.7	7.4	0.9
Observation care services	4.0	5.8	4.2	5.8	0.7
Home services	–1.6	3.8	–1.7	5.9	0.3
Imaging	**0.1**	**2.6**	**0.9**	**3.5**	**11.0**
Standard X-ray	–1.6	1.8	–0.9	3.1	3.1
Ultrasound	0.5	2.6	0.7	3.2	2.9
CT	4.1	4.9	4.2	5.9	2.1
Nuclear	–1.8	–0.1	0.4	2.4	1.3
MRI	2.3	2.7	1.4	1.6	1.2
Major procedures	**0.3**	**2.2**	**1.7**	**5.1**	**7.6**
Musculoskeletal	0.6	2.9	2.0	3.5	2.8
Vascular	0.1	1.0	6.5	14.4	1.5
Cardiovascular	1.7	3.0	1.3	3.6	1.0
Other organ systems	0.3	1.0	0.1	2.3	0.9
Digestive/gastrointestinal	–1.4	0.6	–1.3	0.9	0.8
Skin	0.5	2.0	0.3	2.5	0.5
Eye	–0.8	3.9	–4.9	4.3	0.2
Other procedures	**2.8**	**6.1**	**1.3**	**5.6**	**23.0**
Skin	1.2	3.2	1.6	6.6	4.5
Physical, occupational, and speech therapy	7.3	11.8	8.3	12.9	4.4
Musculoskeletal	0.5	2.0	3.0	3.7	2.5
Eye	2.4	3.2	0.5	2.0	2.3
Radiation oncology	–0.4	3.8	–1.6	3.6	2.0
Other organ systems	1.7	3.7	1.4	6.8	1.7
Digestive/gastrointestinal	0.1	1.6	–2.6	2.0	1.2
Dialysis	–2.0	0.0	0.0	1.5	1.1
Vascular	–4.8	–3.6	–3.9	0.8	1.0
Chiropractic	–1.1	1.2	–1.2	4.8	0.8
Chemotherapy administration	–2.5	0.8	–0.9	0.8	0.5
Injections and infusions: non-oncologic	–1.1	1.4	–3.8	–8.3	0.4
Tests	**0.7**	**2.8**	**1.9**	**2.9**	**5.1**
Anatomic pathology	0.6	3.4	1.2	2.3	2.1
Cardiography	1.0	2.5	4.8	7.8	1.3
Neurologic	0.7	1.8	1.7	–0.1	0.8
Anesthesia	**3.7**	**2.4**	**0.7**	**2.6**	**2.9**

Note: FFS (fee-for-service), CT (computed tomography), MRI (magnetic resonance imaging). Some low-spending categories are not shown but are included in the calculations. We use the number of traditional Medicare beneficiaries enrolled in Part B to define allowed charges per beneficiary.

Source: MedPAC analysis of claims data for 100 percent of traditional Medicare beneficiaries.

Shifts in billing from freestanding offices to hospitals reduce fee schedule–allowed charges but raise overall Medicare spending

Medicare spending is sensitive to shifts in the site of care. Medicare makes both a physician fee schedule payment and a facility payment under the outpatient prospective payment system (OPPS) when a service is provided in a hospital outpatient department (HOPD) (the facility payment accounts for the cost of the service in an HOPD). However, the program makes only a fee schedule payment when a service is furnished in a freestanding office. In 2021, for example, a Level 3 evaluation and management (E&M) office/outpatient visit (Healthcare Common Procedure Coding System code 99213) has an average nonfacility (freestanding office) fee schedule payment rate of $92. By contrast, the average fee schedule payment rate for the visit when provided in an HOPD is $68, and the facility payment to the HOPD is $119 (for a combined payment of $187).[19] Thus, the shift of office visits from freestanding offices to HOPDs reduces the allowed charge billed under the fee schedule (from $92 to $68) but increases the total Medicare payment amount (from $92 to $187).

In recent years, the number of services billed in HOPDs has been increasing, while the number of services provided in freestanding offices has been declining. From 2013 to 2019, for example, the number of E&M office/outpatient visits performed in HOPDs grew by 25 percent, compared with a 5 percent decline in physician offices. Similarly, the number of chemotherapy administration services delivered in HOPDs grew 45 percent, while the number provided in physician offices declined 12 percent. This change in the billed setting increases overall Medicare program spending and beneficiary cost sharing because Medicare generally pays more for the same or similar services in HOPDs than in freestanding offices (Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013, Medicare Payment Advisory Commission 2012). For example, we estimate that in 2019, the Medicare program spent $1.4 billion more than it would have if payment rates for E&M office/outpatient visits in HOPDs were the same as freestanding office rates. In addition, in the same year, beneficiaries' cost sharing was $360 million more than it would have been had payment rates been the same in both settings.

To address the increased spending that results when services shift from freestanding offices to HOPDs, the Commission has recommended adjusting payment rates in the OPPS so that Medicare pays the same amount for E&M office/outpatient visits in freestanding offices and HOPDs (Medicare Payment Advisory Commission 2012). Medicare currently pays a comparable amount for E&M office/outpatient visits in freestanding offices and off-campus HOPDs; however, Medicare continues to pay a higher amount for these visits when provided in on-campus HOPDs.[20] The Commission also has recommended adjusting OPPS rates for services in ambulatory payment classification (APC) groups that meet certain criteria so that payment rates are equal or more closely aligned between HOPDs and freestanding offices (Medicare Payment Advisory Commission 2014).[21] APCs that meet these criteria are those that are unlikely to have costs associated with operating an emergency department, do not have extra costs associated with higher patient complexity in HOPDs, and include services that are frequently performed in physicians' offices (which indicates that these services are likely safe and appropriate to provide in a physician's office). ■

Private PPO payment rates remain higher than Medicare payment rates for clinician services

We compare rates paid by private insurance plans with Medicare rates for clinician services because extreme disparities in payment rates might create an incentive for clinicians to focus primarily on patients with private insurance (this issue is discussed in more detail in Chapter 1). In 2019, payment rates paid by private PPOs for clinician services were 136 percent of traditional Medicare's payment rates, up slightly from 135 percent in 2018.[22] The ratio in 2019 varied by type of service. For example, private insurance rates were 128 percent

of Medicare rates for E&M office visits for established patients but 168 percent of Medicare rates for coronary artery bypass graft surgery.

The gap between private insurance rates and Medicare rates has grown in recent years as private insurance rates have risen while Medicare rates have remained relatively stable. In 2011, private insurance rates were 122 percent of Medicare rates. Notwithstanding the growth in the ratio of private insurance rates to Medicare rates, the vast majority of clinicians continue to participate in the Medicare program. The number of clinicians who opted out of Medicare as of October 2020 (26,000) is substantially outweighed by the number who continue to bill the physician fee schedule (almost 1.3 million in 2019).

The growth in private insurance prices could be a result of greater consolidation of physician practices, which gives physicians greater leverage to negotiate higher prices with private plans. In recent years, an increasing number of physicians have joined larger groups, hospitals, and health systems. For example, between 2009 and 2014, the share of physicians working in practices with more than 50 physicians grew from 16 percent to 22 percent (Medicare Payment Advisory Commission 2017). Between 2016 and 2018, the share of all physicians who were vertically affiliated with health systems grew from 40 percent to 51 percent (Furukawa et al. 2020).[23]

Studies show that private insurance prices for physician services are higher in markets with larger physician practices and in markets with greater physician–hospital consolidation (Baker et al. 2014, Capps et al. 2018, Clemens and Gottlieb 2017, Neprash et al. 2015). Our research found that independent practices with larger market shares and hospital-owned practices received higher private insurance prices for E&M visits than other practices in their market (Medicare Payment Advisory Commission 2017). For example, independent practices with a large market share of E&M visits received an average private insurance price for an E&M visit that was 141 percent of the traditional Medicare rate. By contrast, the average private insurance price received by the smallest independent practices for an E&M visit was about equal to Medicare's rate.

In addition to varying within markets, evidence suggests that private insurance prices for physician services vary widely across markets. A study by the Congressional Budget Office (CBO) using data from 2014 found that the average ratio of private insurance prices to traditional Medicare prices for 20 common physician services was at least 70 percent higher in the most costly market than in the least costly market (Congressional Budget Office 2018). CBO found much less variation in the average ratio of Medicare Advantage (MA) prices to traditional Medicare prices across and within markets. MA plans paid much lower prices than private insurance plans for the 20 services examined in the study, and the median MA prices for these services were almost the same as the median traditional Medicare prices.

Considering our other payment adequacy indicators, we do not believe beneficiaries' access to clinician services is at risk in the near term. However, in the long run, if private payers do not restrain the growth in clinicians' payment rates, eventually the difference between private insurance rates and Medicare rates could grow so large that some clinicians would have an incentive to focus primarily on patients with private insurance instead of Medicare patients.

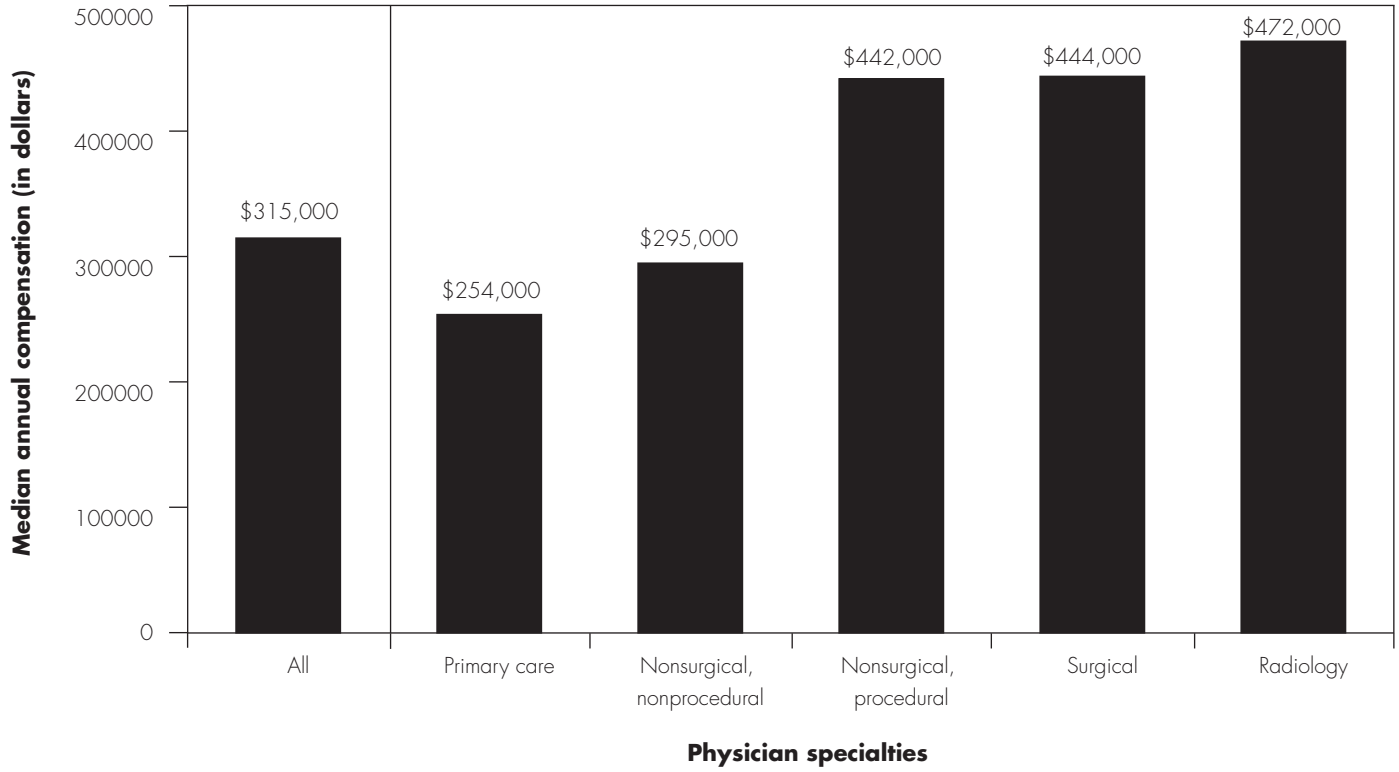
Median physician compensation grew 3.3 percent per year from 2015 to 2019; compensation remains much higher for certain specialties than for primary care

To examine compensation physicians received from all payers, we analyzed 2019 data from SullivanCotter's Physician Compensation and Productivity Survey. From 2015 to 2019, median compensation across all specialties grew at an average annual rate of 3.3 percent and in 2019 was $315,000. From 2015 to 2019, median compensation for primary care physicians increased at an average annual rate of 3.3 percent, the same as for all specialties in the aggregate, but slower than nonsurgical, nonprocedural specialties (4.3 percent) and nonsurgical, procedural specialties (4.1 percent); about the same as surgical specialties (3.4 percent); and faster than radiology (2.4 percent).[24]

Compensation was much higher for some specialties than others. Specialties with the highest median compensation were radiology ($472,000); surgical specialties ($444,000); and nonsurgical, procedural specialties ($442,000) (Figure 4-5, p. 120).[25] Median compensation for radiology was 85 percent higher than median compensation for primary care ($254,000), and median compensation for surgical specialties was 75 percent higher than that of primary care. Psychiatry—which is in the nonsurgical, nonprocedural group—had median compensation of $254,000, the same as primary

FIGURE 4–5

Disparities in physician compensation are widest when primary care physicians are compared with nonsurgical proceduralists, surgeons, and radiologists, 2019



Note: Figure includes all physicians who reported their annual compensation in the survey (*n* = 89,272). The primary care group includes family medicine, internal medicine, and general pediatrics. The nonsurgical, nonprocedural group includes psychiatry, emergency medicine, endocrinology, hospital medicine, nephrology, neurology, physical medicine, rheumatology, and other internal medicine/pediatrics. The nonsurgical, procedural group includes cardiology, dermatology, gastroenterology, pulmonary medicine, and hematology/oncology.

Source: SullivanCotter's Physician Compensation and Productivity Survey, 2020.

care physicians' median compensation.[26] The difference in compensation between primary care and other specialties cannot be explained by differences in hours worked; previous Commission work using data from the Medical Group Management Association (MGMA) showed that there are similar disparities in hourly compensation (Medicare Payment Advisory Commission 2011c).[27]

Physician compensation from all payers reflects the structure of Medicare's fee schedule because many private insurers use a system of RVUs that is similar to Medicare's RVUs but negotiate a conversion factor (a fixed dollar amount) that is different from Medicare's (Clemens and Gottlieb 2017, Congressional Budget Office 2018). Therefore, physician compensation from all payers probably reflects the underpricing of ambulatory E&M visits relative to other services, such as procedures, in Medicare's fee schedule (Medicare Payment Advisory Commission 2018a).[28] Ambulatory E&M visits make up a large share of the services provided by primary care clinicians and certain other specialties (e.g., psychiatry, endocrinology, and rheumatology). The underpricing of these services in the fee schedule contributes to an income disparity between primary care physicians and certain specialists, which has contributed to the decline in the number of primary care physicians in the U.S. in recent years.

Effective January 1, 2021, CMS substantially increased the RVUs for E&M office/outpatient visits—the most common type of ambulatory E&M visit (Centers for

Medicare & Medicaid Services 2020b). For example, CMS increased the total RVUs for a Level 3 E&M visit for an established patient in a freestanding office (Healthcare Common Procedure Coding System code 99213) by 27 percent between 2020 and 2021. CMS increased the national average payment rate (which is a function of the conversion factor and the RVUs) for this code by 21 percent, from $76.15 to $92.47. Owing to budget-neutrality requirements, CMS offset the increase to payment rates for E&M office/outpatient visits in 2021 by reducing payment rates for all fee schedule services. In the Consolidated Appropriations Act, 2021, the Congress scaled back this reduction to the payment rates for fee schedule services. Specifically, the Congress increased payment rates for all fee schedule services by 3.75 percent in 2021 (this increase does not apply after 2021) and delayed implementation of a new add-on code for E&M office/outpatient visits by three years.[29]

The Commission strongly supports raising the RVUs for E&M office/outpatient visits because this action is an important first step to address the long-term devaluation of these services. We also support CMS's decision to implement this change in a budget-neutral manner because doing so will help rebalance the fee schedule from services that have become overvalued (e.g., procedures, imaging, and tests) to services that have become undervalued—thus improving payment accuracy (Centers for Medicare & Medicaid Services 2020b). Maintaining budget neutrality could also help reduce the large gap in compensation between primary care physicians and certain specialists, which could help increase the supply of primary care physicians in the U.S. However, CMS still needs to improve the overall accuracy of the fee schedule and further rebalance the fee schedule toward primary care. The Commission has previously recommended that CMS collect accurate, timely data to set RVUs and that the Congress establish a per beneficiary payment for primary care practitioners (see text box on previous recommendations, p. 123).

Input costs for clinicians are projected to increase from 2021 to 2022

The MEI, which measures the average annual price change in the market basket of inputs used by clinicians to furnish services and is adjusted for economy-wide productivity, increased by 1.5 percent in 2019 (Centers for Medicare & Medicaid Services 2013). CMS's forecasted growth for the MEI (as of the third quarter of 2020) in 2020, 2021, and 2022 is 1.7 percent, 1.3 percent, and 1.6 percent, respectively (projections subject to change). The MEI consists of two main categories: (1) physicians' compensation and (2) physicians' practice expenses (e.g., compensation for nonphysician staff, rent, equipment, and professional liability insurance). The index's cost categories (e.g., physician compensation, medical equipment) and cost weights (each category's share of total costs) are based on data on physicians' expenses from 2006, which raises questions about the continued accuracy of the MEI.[30] CMS lacks a reliable, ongoing source of data to update the MEI's cost categories and cost weights. In 2011, the Commission recommended that CMS regularly collect data from a cohort of efficient practices to establish more accurate work and practice expense RVUs. As part of this data collection, CMS could gather data on physicians' practice costs and use that information to update the MEI.

How should Medicare payments change in 2022?

The Commission's deliberations on payment adequacy for clinicians are informed by data assessing beneficiaries' access to services, the quality of their care, and Medicare payments and providers' costs. We find that, on the basis of these indicators, there should be no update to payment rates in 2022, as specified in current law. We note that, under current law, the 3.75 percent increase to payment rates for 2021 expires after 2021.

On measures of access to clinician services, the Commission continues to find that beneficiaries' access to care appears generally stable. Overall, Medicare beneficiaries generally have access to clinician services comparable with that of privately insured individuals ages 50 to 64. A large majority of beneficiaries report using an appropriate usual source of care, say their usual care provider spends enough time with them, report being satisfied with their care, and do not forgo or delay care. Growth in the number of clinicians billing the program outpaced beneficiary growth from 2014 to 2019, but the mix of clinicians changed. The number of primary care physicians decreased slightly, while the number of specialists steadily increased, and the number of APRNs and PAs grew rapidly. The share of clinicians who bill Medicare as a participating provider remains very high. The number of clinician encounters per beneficiary increased modestly over time, with faster growth from 2018 to 2019 (2.1 percent) compared with the average

annual growth rate from 2014 to 2018 (1.1 percent). The number of encounters with primary care physicians declined while encounters with APRNs and PAs grew dramatically.

In terms of quality, geographic variation in ACS hospitalizations and ED visits signals opportunities to improve the quality of ambulatory care in traditional Medicare. In addition, there is substantial use of low-value care in traditional Medicare.

Traditional Medicare's allowed charges for clinician services grew faster from 2018 to 2019 than in prior years. From 2018 to 2019, across all services, allowed charges per beneficiary grew by 3.7 percent. In 2019, private insurance payment rates for clinician services were 136 percent of traditional Medicare's payment rates, up slightly from 135 percent in 2018. Median physician compensation from all payers grew at an average annual rate of 3.3 percent from 2015 to 2019, although compensation was much lower for primary care physicians than for physicians in certain other specialties in 2019. As of the third quarter of 2020, input prices for clinicians were projected to increase by 1.6 percent in 2022.

RECOMMENDATION 4

For calendar year 2022, the Congress should update the 2021 Medicare payment rates for physician and other health professional services by the amounts determined under current law.

RATIONALE 4

Overall, access to clinician services for Medicare beneficiaries appears stable and comparable with that for privately insured individuals. Other measures of payment adequacy are stable and consistent with prior years. Therefore, the Commission does not see a reason to diverge from the current-law policy of no update for 2022. We note that, under current law, the 3.75 percent increase to payment rates for 2021 expires after 2021.

IMPLICATIONS 4

Spending

- No change as compared with current law.

Beneficiary and provider

- The Commission's recommendation of the current-law update should not affect beneficiaries' access to care or providers' willingness and ability to furnish care. ■

Previous Commission recommendations to improve the accuracy of prices for ambulatory evaluation and management services and establish a per beneficiary payment for primary care clinicians

The Commission has long been concerned that ambulatory evaluation and management (E&M) services, which make up a large share of the services provided by primary care clinicians and certain other specialties (e.g., psychiatry, endocrinology, and rheumatology), are underpriced in the physician fee schedule compared with other services, such as procedures (Medicare Payment Advisory Commission 2018a). Ambulatory E&M services include office visits, hospital outpatient department visits, nursing facility visits, and home visits.

In 2011, the Commission recommended that CMS use a streamlined method to regularly collect data from a cohort of efficient practices—including service volume and work time—to establish more accurate work and practice expense relative value units (RVUs) (Medicare Payment Advisory Commission 2011a, Medicare Payment Advisory Commission 2011b). These data should be used to calculate the amount of time that a clinician worked over the course of a week or month and compare it with the time estimates in the fee schedule for all of the services that the clinician billed over the same period. If the fee schedule's time estimates exceed the actual time worked, this finding could indicate that the time estimates—and, hence, the work RVUs—are too high. CMS could use this approach to identify groups of services that are likely overpriced, carefully review those services, and adjust the work RVUs accordingly.

Practice expense RVUs—which account for the cost of operating a practice—are based on data from a survey of total practice costs incurred by nearly all specialty groups. Because this survey was conducted in 2007 and 2008, practice expense RVUs probably do not reflect current practice costs. CMS has not developed a strategy for updating practice cost data. However, CMS could regularly collect data on total practice costs along with data on volume and work time from a cohort of efficient practices, as the Commission recommended in 2011 (Medicare Payment Advisory Commission 2011a).

In addition to concern about the mispricing of ambulatory E&M services, the Commission contends that the fee schedule—with its orientation toward discrete services that have a definite beginning and end—is not well designed to support primary care, which requires ongoing care coordination for a panel of patients. Consequently, in 2015 the Commission recommended that the Congress establish a per beneficiary payment for primary care clinicians to replace the expired Primary Care Incentive Payment (PCIP) program, which provided a 10 percent bonus payment on fee schedule payments for certain E&M visits provided by primary care clinicians (Medicare Payment Advisory Commission 2015). A monthly payment based on the total amount of PCIP payments in 2015 ($686 million) would initially amount to about $2.35 per beneficiary.[31]

The Commission recommended that the additional payments to primary care clinicians be in the form of a per beneficiary payment to move away from the approach of paying separately for each discrete service. The payment would provide funds to support the investment in infrastructure and staff that facilitate care management and care coordination. Funding for the per beneficiary payment would come from reducing payment rates for all services in the fee schedule other than ambulatory E&M visits provided by any clinician. This method of funding would be budget neutral and would help rebalance the fee schedule toward primary care clinicians. ■

APPENDIX A

Findings from the Commission's 2020 access-to-care telephone survey

TABLE 4A–1

Elderly Medicare beneficiaries and older privately insured individuals had comparable access to clinician care, 2016–2020

	Medicare (ages 65 and older)					Private insurance (ages 50–64)				
Survey question	**2016**	**2017**	**2018**	**2019**	**2020**	**2016**	**2017**	**2018**	**2019**	**2020**
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"										
For routine care										
Never	68%	73%[ab]	70%[a]	72%[b]	69%[a]	67%[b]	69%[ab]	64%[ab]	74%	73%[a]
Sometimes	22	20[ab]	20[a]	20	22[a]	23[b]	22[ab]	26[ab]	19	20[a]
Usually	4[b]	3	5[b]	3	3	5	4	5	4	4
Always	3	3	3[a]	3	3	4[b]	3	4[ab]	3	3
For illness or injury										
Never	79[a]	80[a]	79[a]	80	79	75[ab]	76[ab]	74[ab]	81	80
Sometimes	16[a]	15[a]	15[a]	14	15	19[ab]	18[ab]	19[ab]	15	15
Usually	2[a]	2	2	2	2	3[a]	2	3	2	3
Always	2[a]	1[a]	2[b]	2	2	3[a]	2[a]	2	1	2
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"										
Share answering "Yes"	11[a]	11	11[a]	9	10	12[ab]	12	14[ab]	10	11
Looking for a new provider: "In the past 12 months, have you tried to get a new...?" (Share answering "Yes")										
Primary care provider	8[a]	9[a]	10[b]	8	8	10[ab]	11[ab]	10[b]	9	7
Specialist	18[b]	17[ab]	19[ab]	17[b]	15	18[b]	20[ab]	21[ab]	15	13
Getting a new provider: Among those who tried to get an appointment with a new primary care provider or a specialist in the past 12 months, "How much of a problem was it finding a primary care provider/specialist who would treat you? Was it..."										
Primary care provider										
No problem	64	69[ab]	71[b]	72[ab]	60	63	59[a]	67[b]	62[a]	57
Share of total insurance group	*5*	*6*[b]	*7*[b]	*5*	*5*	*6*[b]	*6*[b]	*7*[b]	*5*[b]	*4*
Small problem	15	13	13	13[a]	16[a]	16[b]	18	16[b]	20[a]	24[a]
Share of total insurance group	*1*	*1*[a]	*1*	*1*[a]	*1*	*2*	*2*[a]	*2*	*2*[a]	*2*
Big problem	20	14[ab]	14[b]	14[b]	22	20	22[a]	16	17	18
Share of total insurance group	*2*	*1*[a]	*1*	*1*	*2*	*2*	*2*[ab]	*2*	*2*	*1*
Specialist										
No problem	82	83	84[b]	85[ab]	79	79	81	80	79[a]	77
Share of total insurance group	*15*[b]	*14*[b]	*16*[b]	*14*[ab]	*12*	*14*[b]	*16*[b]	*17*[b]	*12*[ab]	*10*
Small problem	10	11	7	6[a]	9	9	11	9	11[a]	11
Share of total insurance group	*2*	*2*[b]	*1*	*1*	*1*	*2*	*2*[b]	*2*	*2*	*1*
Big problem	8[ab]	5[ab]	8[b]	8	11	11[a]	8[a]	10	9	11
Share of total insurance group	*1*	*1*[ab]	*1*	*1*	*2*	*2*	*2*[a]	*2*	*1*	*2*

Note: Totals may not sum to 100 because of rounding and because the table excludes the following responses: "Don't know" and "Refused." Sample sizes for each group (Medicare and private insurance) are approximately 4,000. Sample sizes for individual questions varied. Survey includes beneficiaries enrolled in fee-for-service Medicare or Medicare Advantage and excludes beneficiaries under the age of 65.

[a] Statistically significant difference between the Medicare and private insurance groups in the given year (at a 95 percent confidence level).

[b] Statistically significant difference from 2020 within the same insurance category (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone surveys conducted from 2016 to 2020.

TABLE 4A–2

Slightly higher shares of certain non-White individuals reported unwanted delays in accessing care compared with White individuals, regardless of insurance type, 2020

Survey question	Medicare (ages 65 and older) All	Medicare (ages 65 and older) White	Medicare (ages 65 and older) Non-White	Private insurance (ages 50–64) All	Private insurance (ages 50–64) White	Private insurance (ages 50–64) Non-White
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"						
For routine care						
Never	69%[a]	71%	62%	73%[a]	75%	69%
Sometimes	22[a]	22	24	20[a]	19	22
Usually	3	3	3	4	4	4
Always	3	2	4	3	2	4
For illness or injury						
Never	79	80	74	80	81	77
Sometimes	15	15	17	15	15	15
Usually	2	2	2	3	2	4
Always	2	1	2	2	1	3
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"						
Share answering "Yes"	10	10	10	11	10	11
Looking for a new provider: "In the past 12 months, have you tried to get a new…?" (Share answering "Yes")						
Primary care provider	8	8	9	7	7	7
Specialist	15	15	13	13	14	11
Getting a new provider: Among those who tried to get an appointment with a new primary care provider or a specialist in the past 12 months, "How much of a problem was it finding a primary care provider/specialist who would treat you? Was it…"						
Primary care provider						
No problem	60	61	57	57	54	68
Share of total insurance group, by race	*5*	*5*	*5*	*4*	*4*	*5*
Small problem	16[a]	16	16	24[a]	25	24
Share of total insurance group, by race	*1*	*1*	*1*	*2*	*2*	*2*
Big problem	22	22	23	18	20	8
Share of total insurance group, by race	*2*	*2*	*2*	*1*	*1*	*1*
Specialist						
No problem	79	81	76	77	78	71
Share of total insurance group, by race	*12*	*12*	*9*	*10*	*11*	*8*
Small problem	9	8	13	11	10	14
Share of total insurance group, by race	*1*	*1*	*2*	*1*	*1*	*2*
Big problem	11	11	10	11	11	15
Share of total insurance group, by race	*2*	*2*	*1*	*2*	*2*	*2*

Note: Totals may not sum to 100 because of rounding and because the table excludes the following responses: "Don't know" and "Refused." Respondents who did not report race or ethnicity were not included in "White" or "Non-White" results, but were included in "All" results. "White" in the table refers to non-Hispanic White respondents. "Non-White" refers to Hispanic respondents and non-Hispanic Black respondents. Sample sizes for each group (Medicare and private insurance) were approximately 4,000 in 2020. Sample sizes for individual questions varied. Survey includes beneficiaries enrolled in traditional Medicare or Medicare Advantage and excludes beneficiaries under the age of 65.

[a] Statistically significant difference between the Medicare and private insurance groups in the given year (at a 95 percent confidence level).

[b] Statistically significant difference by race within the same insurance category in the given year (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone survey conducted in 2020.

TABLE 4A–3

No statistically significant difference in access to care for urban and rural residents, 2020

Survey question	Medicare (ages 65 and older) All	Medicare (ages 65 and older) Urban	Medicare (ages 65 and older) Rural	Private insurance (ages 50–64) All	Private insurance (ages 50–64) Urban	Private insurance (ages 50–64) Rural
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"						
For routine care						
Never	69%[a]	68%[a]	72%	73%[a]	73%[a]	75%
Sometimes	22[a]	23[a]	20	20[a]	20[a]	19
Usually	3	3	3	4	4	3
Always	3	3	1	3	3	2
For illness or injury						
Never	79	78	82	80	79	84
Sometimes	15	16	13	15	15	12
Usually	2	2	2	3	3	1
Always	2	2	1	2	2	2
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"						
Share answering "Yes"	10	10	10	11	11	9
Looking for a new provider: "In the past 12 months, have you tried to get a new...?" (Share answering "Yes")						
Primary care provider	8	8	8	7	8	8
Specialist	15	15	13	13	14	13
Getting a new provider: Among those who tried to get an appointment with a new primary care provider or a specialist in the past 12 months, "How much of a problem was it finding a primary care provider/specialist who would treat you? Was it..."						
Primary care provider						
No problem	60	59	61	57	57	53
Share of total insurance group, by area	*5*	*5*	*5*	*4*	*4*	*4*
Small problem	16[a]	18	11	24[a]	25	20
Share of total insurance group, by area	*1*	*1*	*1*	*2*	*2*	*2*
Big problem	22	21	26	18	17	28
Share of total insurance group, by area	*2*	*2*	*2*	*1*	*1*	*2*
Specialist						
No problem	79	80	77	77	78	68
Share of total insurance group, by area	*12*	*12*	*10*	*10*	*11*	*9*
Small problem	9	8	13	11	11	17
Share of total insurance group, by area	*1*	*1*	*2*	*1*	*1*	*2*
Big problem	11	11	10	11	11	15
Share of total insurance group, by area	*2*	*2*	*1*	*2*	*2*	*2*

Note: Totals may not sum to 100 because of rounding and because the table excludes the following responses: "Don't know" and "Refused." Sample sizes for each group (Medicare and private insurance) were approximately 4,000 in 2020. Sample sizes for individual questions varied. Survey includes beneficiaries enrolled in traditional Medicare or Medicare Advantage and excludes beneficiaries under the age of 65. The Commission uses the Census Bureau definitions of "urban" and "rural." The Census Bureau classifies as "urban" all territory, population, and housing units located within an urbanized area (UA) or an urban cluster (UC). It delineates UA and UC boundaries to encompass densely settled territory, which consists of core census block groups or blocks that have a population density of at least 1,000 people per square mile and surrounding census blocks that have an overall density of at least 500 people per square mile. In addition, under certain conditions, less densely settled territory may be part of each UA or UC. The Census Bureau's classification of "rural" consists of all territory, population, and housing units located outside of UAs and UCs.

[a] Statistically significant difference between the Medicare and private insurance groups in the given year (at a 95 percent confidence level).

[b] Statistically significant difference by area type within the same insurance category in the given year (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone survey conducted in 2020.

Endnotes

1 Throughout this chapter, we use the term "fee-for-service (FFS) Medicare" or "traditional Medicare" as equivalents to the CMS term "Original Medicare." Collectively, we distinguish the payment model represented by these terms from other models, such as Medicare Advantage or advanced alternative payment models, that may use FFS mechanisms, but which are designed to create different financial incentives.

2 Although nearly all clinician services are paid under the fee schedule, some are paid under other payment systems, such as the prospective payment system for federally qualified health centers.

3 For further information, see the Commission's *Payment Basics: Physician and Other Health Professional Payment System* at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_physician_final_sec.pdf?sfvrsn=0.

4 Primary care visits include E&M office visits, wellness visits, preventive medicine counseling, and other services.

5 Under Section 319 of the Public Health Services Act, the Secretary of Health and Human Services may determine that a disease or disorder presents a PHE or that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. The Secretary first determined the existence of a coronavirus PHE, based on confirmed cases of COVID-19 in the U.S., on January 31, 2020. At the time of publication, the coronavirus PHE had been renewed several times for 90 days periods and is set to expire in mid-April 2021.

6 A substantial number of clinicians billed for 15 or fewer beneficiaries in a given year, but they accounted for a small share of services and allowed charges. For example, in 2019, about 17 percent of clinicians who billed the fee schedule billed for 15 or fewer beneficiaries, but these clinicians billed for less than 1 percent of total allowed charges.

7 We used the number of total Part B beneficiaries, including those in traditional Medicare and Medicare Advantage, to calculate the ratio of physicians and other health professionals per 1,000 beneficiaries because we assume that clinicians generally furnish services to beneficiaries covered under both programs.

8 APRNs include clinical nurse specialists, nurse practitioners, certified registered nurse anesthesiologists, and certified nurse midwives.

9 In such scenarios, the beneficiary is billed 20 percent cost sharing for 95 percent of the fee schedule amount, plus the difference between 95 percent of the fee schedule amount and the total amount billable by the provider (which can reach up to 109.25 percent of the fee schedule amount for participating providers).

10 The behavioral health clinicians referenced here are psychiatrists, clinical psychologists, and clinical social workers.

11 The oral health professionals referenced here are dentists, oral surgeons, and maxillofacial surgeons.

12 The primary care specialties referenced here are family medicine, internal medicine, and pediatric medicine.

13 Specifically, we define "encounters" as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and national provider identifiers of the clinicians who billed for the service.

14 This number is based on our count of beneficiaries who had at least one encounter recorded in claims data and the total number of traditional Medicare beneficiaries enrolled in Part B in the 2020 Medicare Trustees report.

15 Primary care physicians billed for very few services classified as "major procedures" or "anesthesia," so these categories of services were excluded from this analysis.

16 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

17 The roughly 3,400 Dartmouth-defined HSAs are a collection of ZIP codes whose residents receive most of their hospitalizations from that respective area's hospitals.

18 It is challenging to reliably identify low-value care with claims data because claims may not have enough clinical detail to distinguish between appropriate and inappropriate use. Thus, these measures allow for trade-offs between the sensitivity and specificity of each measure. Schwartz and colleagues developed two versions of each measure: a broader one with higher sensitivity (and lower specificity) and a narrower one with lower sensitivity (and higher specificity) (Schwartz et al. 2014). Increasing the sensitivity of a measure captures more potentially inappropriate use but is also more likely to misclassify some appropriate use as inappropriate. Increasing a measure's specificity leads to less misclassification of appropriate use as inappropriate, at the expense of potentially missing some instances of inappropriate use.

19 When this type of visit is provided in an HOPD, it is billed as Healthcare Common Procedure Coding System code G0463. We used the OPPS rate for the HOPD payment.

20 Section 603 of the Bipartisan Budget Act of 2015 prohibits HOPDs that began billing under the OPPS on or after November 2, 2015, and are located off a hospital campus from billing under the OPPS after January 1, 2017. In 2020, the payment rate for services provided at these off-campus HOPDs was equal to 40 percent of the rate under the OPPS. On-campus HOPDs, off-campus HOPDs that began billing before November 2, 2015, and dedicated emergency departments were not affected by this policy change. However, as of 2019, Medicare pays all off-campus HOPDs (regardless of when they began billing under the OPPS) an amount equal to 40 percent of the OPPS rate for office/outpatient E&M visits.

21 For the OPPS, CMS classifies services into APC groups on the basis of clinical and cost similarity; all services within an APC group have the same payment rate.

22 This analysis used data on paid claims for PPO enrollees of a large national insurer that covers a wide geographic area across the U.S. The payments reflect the insurer's allowed amount (including allowed cost sharing). The data exclude any remaining balance billing and payments made outside of the claims process, such as bonuses or risk-sharing payments. Only services paid under Medicare's physician fee schedule were included, and anesthesia services were excluded.

23 In this study, health systems are organizations with at least one acute care hospital and one physician group providing comprehensive care that are connected through common ownership or joint management (Furukawa et al. 2020).

24 To control for annual changes in survey respondents, we based the percentage change on a cohort analysis in which the sample was restricted to physicians who were present in both the 2015 and 2019 data.

25 The nonsurgical, procedural specialties in the analysis are cardiology, dermatology, gastroenterology, pulmonary medicine, and hematology/oncology.

26 In addition to psychiatry, the nonsurgical, nonprocedural group includes emergency medicine, endocrinology, hospital medicine, nephrology, neurology, physical medicine, rheumatology, and other internal medicine/pediatrics. The primary care specialties in the analysis are family medicine, internal medicine, and general pediatrics.

27 This analysis was based on MGMA data from 2007. It found that hourly compensation for nonsurgical, procedural specialties and radiology was more than double hourly compensation for primary care.

28 Ambulatory E&M services include office visits, hospital outpatient department visits, visits to patients in certain other settings such as nursing facilities, and home visits.

29 The new add-on code is G2211 (visit complexity inherent to evaluation and management).

30 CMS uses price proxies (such as the consumer price index and employment cost index) to calculate annual changes in the MEI.

31 We estimate, based on claims data from 2015, that primary care clinicians would receive per beneficiary payments for 127 beneficiaries, on average.

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